

# MENTAL HEALTH

PRICE 1/-  
ANNUAL  
SUBSCRIPTION  
POST FREE 5/-

PUBLISHED BY  
THE NATIONAL  
ASSOCIATION FOR  
MENTAL HEALTH  
39 QUEEN ANNE ST.  
LONDON, W.I



VOL. VII

MAY, 1948

No. 4

# NATIONAL ASSOCIATION FOR MENTAL HEALTH

**Patron :**

H.R.H. THE DUCHESS OF KENT

**President :**

THE RT. HON. R. A. BUTLER, P.C., M.P.

**Vice-Presidents :**

THE LORD ALNESS, G.B.E.

DR. H. CRICHTON-MILLER

DR. HELEN BOYLE

DR. DORIS M. ODLUM

DAME EVELYN FOX

MRS. ST. LOE STRACHEY

LADY ST.JOHN HOPE

DR. F. DOUGLAS TURNER, C.B.E.

**Chairman of Council :**

THE RT. HON. THE EARL OF FEVERSHAM, D.S.O., D.L., J.P.

**Vice-Chairman :**

THE LADY NORMAN

**Hon. Treasurer :**

SIR OTTO NIEMEYER, G.B.E., K.C.B.

**Medical Director :**

KENNETH SODDY, M.D., D.P.M.

**General Secretary :**

MISS M. C. OWEN, M.B.E., M.A.





# MENTAL HEALTH

Published by the  
NATIONAL ASSOCIATION FOR MENTAL HEALTH

EDITOR :

R. F. TREDGOLD, M.D., D.P.M.

Vol. VII. No. 4.

May, 1948.

Price 1/6

## CONTENTS

	<i>Page</i>
EDITORIAL .....	86
CHILD GUIDANCE. R. F. BARBOUR, F.R.C.P., D.P.M. ....	86
JUVENILE DELINQUENCY. J. D. W. PEARCE, M.A., M.D., F.R.C.P.E., D.P.M. ....	90
"... AND NOBODY CARES FOR ME!" EDWARD LIGHTOWLER .....	94
NATIONAL HEALTH SERVICE ACT, 1946. LOCAL AUTHORITIES' SCHEMES FOR A MENTAL HEALTH SERVICE .....	96
THE INTERNATIONAL CONGRESS ON MENTAL HEALTH .....	97
HOW CAN THE MENTAL NURSE CONTRIBUTE TO THE RECOVERY OF THE DEPRESSED PATIENT ? JOAN EVANS .....	98
NEWS AND NOTES .....	100
BOOK REVIEWS .....	104
FILM REVIEWS .....	109
CORRESPONDENCE .....	110
RECENT PUBLICATIONS .....	111

## Editorial

"The child is father of the man" is a saying whose apparent paradox must have delighted its original hearers as much as its speaker. Unfortunately it has now become so well known that it is wearisome instead of delightful, and its meaning seldom considered. In a culture like the Athenian, where all are seeking for some new thing, there is little patience with well-known phrases, and anything which seems familiar seems also dull. But Mr. Justice Holmes' warning is still timely—that we need more study of the obvious and less investigation of the obscure.

There is, therefore, no need to apologize for emphasizing the paramount place of Child Guidance in preventive medicine. This is particularly so at a time when the raising of the school-leaving age is accompanied by the shortage of teachers, and the increase in crime by the shortage of police.

We are fortunate in this number to be able to publish accounts of three closely linked aspects of the problem—a survey of Child Guidance and its scope, a study of the problem of juvenile delinquency, and a description of a school.

Naturally we do not imply that these are the only aspects—and indeed it is to be hoped that the new Health Services will be able to co-ordinate and integrate all the existing ones into a more comprehensive whole. We may help them to do so if we can get clear in our own minds what are the main problems in this field for doctor, nurse, social worker, probation officer and educationalist, where their functions overlap and how they can collaborate. It is evident from the writers of the articles in this number that the best approach is by means of a team and not by a single specialist. The contribution of each individual in the team is essential.

## Child Guidance\*

By R. F. BARBOUR, F.R.C.P., D.P.M.

The study of the psychiatric problems of adults has shown that they mostly start in early life before the individual has reached school age. It is in the first five years of life that the emotional attitudes of a person are formed, his independence or sense of inferiority, his reaction to authority and to people of his own age. These are the emotional patterns which determine neurosis in later life. When the importance of the child's psychological problems was first realized, people shrank from using the word "psychiatric" to describe them, as that term was almost synonymous with "mental" or "lunatic" and instead the term "Child Guidance" was used, the word "guidance" emphasizing the natural growing powers of the child, who could be guided to grow aright.

All behaviour can be regarded as the resultant of three sets of forces. There is first the inborn heredity and constitution, then early training and experiences, and finally present environment, both material and social. The same behaviour, stealing, bed-wetting or nightmares, will be assessed very differently according to the contributory factors. An only child of university capacity, but with a broken home, who steals, is a very different problem from the tenth of twelve children who sits near the bottom of his class and whose only recreational facilities are the street or bombed-out site. In each case the relevant facts under these three different headings must be found out, a time consuming process but in the long run well worth while. It is possible for a single properly qualified individual

to elicit all the facts but in clinics the custom has grown up of having a team of three, psychiatrist, psychologist and psychiatric social worker, though some clinics would add two other members to the team, paediatrician and play therapist.

Before seeing how the team works it is worth while considering where the child should be seen. Practice differs, at the one end there is the mental hospital out-patient clinic, at the other the individual interview at the child's own school. The hospital staff stress the continuity of patient and symptoms with full facilities for laboratory investigation and in-patient treatment, while those who favour the interview in school, point out that the child is seen amid familiar surroundings, that he can be observed in the playground and that he does not even know that he is being thought of as a "special case", let alone a patient. Still somewhat opposed, but less markedly, are the Child Guidance Centre and the psychological clinic at a Children's Hospital. The latter may have unpleasant associations and arouse memories of injections, tonsils; the word "centre" is preferred by many educational psychologists as it is non-medical. In the middle comes the Child Guidance Clinic, usually psychiatric in its approach, but sometimes more broadly medical with a psychiatrist only consulting as required.

From the foregoing it can be seen that the emotional problems of children can be approached from two different angles, the medical and the educational. The same problem can be regarded as either retarded

\* This is the second article of a series concerning services of interest to the social worker, contributed by invitation.—Ed.

development or as stunted growth ; the latter has a medical flavour, the former an educational. As will be seen later, it is not always obvious which member of the team should be the therapist. It has been suggested that if several children could be "trained" together then it was an educational problem, but if individual attention was required then it was medical, but group therapy has made this distinction pointless. Legal requirements, as for instance, the signature on the Ministry form 2 H.P., make the doctor's examination essential where any form of special educational treatment is required.

It is very desirable that "access" to a clinic should be as easy as possible. Most referrals will come through educational or medical channels, but parents should be allowed to come direct. The problem may be one they do not wish discussed outside the home or they may be over-anxious, the latter at first sight might seem a waste of time but the over-anxious parent "infects" his child so that there is in fact a problem to be dealt with, even though it is 90 per cent. on the parent's side.

At a Child Guidance Centre or Clinic then one will expect to find a team of three. Usually it is the psychiatric social worker who takes the history from the parent, nineteen times out of twenty this is the mother. The history will cover material facts such as the living conditions and opportunities for play but it will deal also with the parents and other members of the family. The early development of the child, major events such as illnesses, evacuation or change of school are recorded. One is on the look-out for significant correlations such as symptoms starting after the birth of the next child, when father was demobilized or when mother started to go out to work. Of special importance is how the problem appeared to the parents and their reaction to it. While mother is being interviewed the psychologist may be seeing the child. An estimate of the intelligence will be made, his educational attainments measured. This is a standardized situation, rather like school and the child is asked set questions. By contrast, the interview with the psychiatrist is freer, there is more give and take so that the emotional problems are more easily seen. Usually some form of projection test is also used so that the child by his actions and words reveals his problems as he feels them, this is often in marked contrast to his actual words which may deny the problem that is too real to be voiced. A period of free activity, play or blackboard, follows and a physical examination with special attention to minor degrees of deafness, impaired vision, rounds off the interview.

Each of these interviews will take on the average, an hour. A conference of the team follows, each contributing their side of the picture.

At the Bristol Clinic we see eight or nine new cases each week, the following six cases were all seen within one week, the three others were an enuretic, another "care and protection" case, and a stammerer.

(1) *Boy, aged 9½ years, referred by speech therapist at request of headmaster who was concerned about his educational backwardness and wondered how far it was due to his left-handedness.*

An only child, his father in the R.A.F. was posted as "missing, presumed killed" in 1942; five years later, two years after the end of the war, this boy had still not been told that his father would never come back. His mother, tense, with an artificial laugh, was in half-time work. They both lived with her parents.

His early development showed he was slow in learning to talk, toilet training was completed by two years. He was always a poor sleeper.

Physical examination showed a healthy lad, left-handed and left-eyed. His finger nails were bitten, his speech showed little hesitation but he could not pronounce "sc" as in school or skate.

His intelligence quotient was 93, he was twelve months retarded in his educational work.

He was excessively polite, asked permission before doing anything, unless occupied his fingers were continually intertwining. He was on the verge of tears when talking about his father and again when talking about his pet dog which had been destroyed. Three wishes of the boy in the story completion test were to have (1) some friends, (2) friends to play with him, (3) friends every day.

The picture is a complex one, constitutional handicaps in his left-handedness and speech difficulty, environmental in the all-adult house in which he lives and in the past the lack of a clear explanation about his father's death.

(2) *Boy, aged 16½ years, referred by the magistrates on account of stealing clothes from his father, which he then sold.*

The youngest by six years of four children. His father is a metal polisher. His mother has gone to work as the parents could not rely on this boy earning regularly.

His early development was normal. His mother thought she might have spoiled him. He had a good school report, was considered trustworthy and for a time was class monitor. He held his first job for nine months, but left on medical advice as he was getting skin trouble, thereafter he was in a series of jobs usually leaving for trivial reasons, or being sacked for inefficiency.

He was before the court once for playing on the railway line, but otherwise his record seemed to be good until six months prior to his present offence. Later it became clear that in fact there had been problems, staying away from work half-a-day, breaking into the electric meter, but these were not disclosed by his parents. During the last six months he had "gone to pieces", staying out at night, twice taking clothes from home and selling them. He played cards, used his pay to go horse-riding and was said to keep bad company, to wit an army deserter.

His intelligence quotient was 80—his reading age 2 years behind his mental age, his arithmetic at the adult level.

Physical examination showed a left-handed lanky lad, who held himself poorly.

The basic problem was the mother's attitude—originally a "good boy" he did well while a scaffolding was provided, and he had an adequate

## MENTAL HEALTH

series of outlets, but left to himself his desire for excitement and to have a good time, soon got him into difficulty.

(3) *Girl, aged 5½ years, referred by School Medical Department on account of fears, being shy and frightened.*

The third of five children, the sixth born soon after her, died at four months. The father a dustman, was discharged from the army on account of psycho-neurosis. The mother, rough-and-ready, works in a factory.

It was a normal pregnancy but when a year old the child was removed to the fever hospital with measles. Walking and talking were late, speech is backward.

Intelligence quotient 94, would not be separated from her mother during the test and turned to her for help.

Physical examination showed a saddle-shaped nose with rhinorrhoea.

A week after the referral and before the child had been seen, she was in hospital for 48 hours for tonsillectomy. This aggravated all the symptoms.

In this case the attitude of the mother, the low state of health of the child, the traumatic effect of the operation seemed to be the main factors.

(4) *Boy, aged 5½ years, referred by School Medical Department on account of enuresis.*

The elder of two children, father is only at home at week-ends. Mother irritated by her children—"such a tie".

A wanted baby, but he cried "night and day". Talking was slow, walking normal, "resisted the pot". Was dry at 2½ years, but enuresis started at 3½ years, shortly after the birth of his sister. Now he "wants attention", "likes mucking about". Is still put to bed with napkins on.

Physical examination was negative.

He had an intelligence quotient of 116, his work was very imaginative but egocentric.

(5) *Boy, aged 14 years, referred by Juvenile Court as "exposed to moral danger, having parents not exercising proper care and guardianship".*

The second of six children, he lived in London for 6 years, going to hospital with his sister for some skin condition; he did not return home but was sent to a cottage home from which his parents reclaimed him 6½ years later; during the period they neither visited nor wrote to him. Shortly after his return home he began to take bread and cakes, for this he was soundly thrashed. Later a 10s. note disappeared at home and this boy was taken to the police station, but nothing was proved, the boy maintaining he knew nothing about it. He was locked in his bedroom and given only scraps of food "to teach him". The maltreatment was so obvious that an aunt took pity on him and he went to live with her, but she got crowded out, with a son being demobilized, so the boy was returned to his home, he ran away, took a cigarette case from a parked car and eventually was picked up by the police. Father refused to go bail.

Physical examination was non-contributory.

His intelligence quotient was 81, his educational work only some six months retarded.

The boy himself presented rather a pathetic spectacle, like a "fish out of water", no social contacts and longing to get back to the cottage home where he had spent the happiest years of his life.

(6) *Boy, aged 8 years, referred for advice re placement.*

Illegitimate. Sent, aged 2 years, to a residential nursery as he was reported to be backward, defiant, aggressive and moody. Aged 6½ years, had improved considerably and foster-home placement was suggested, this occurred when he was 7 years. Within two months the foster father got a job in the north of England and the family moved. Was placed in another foster-home, but he did not fit in, so transferred to small home school. But after six months was considered to be too babyish and the foster-mother had been offered more attractive children so he was again moved; by now he was enuretic and occasionally soiled.

His intelligence quotient was 87, but his behaviour and general attitude to life suggested a much lower figure.

Physical examination showed him to be short-sighted, the glasses-prescription had last been known of nine months previously.

The stated reason for referral may be physical, psychological or social; asthma, "faints", headaches—fears of the dark, jealousy, loneliness—traunting, sex offences, stealing, but no matter in which sphere the main problem is, there are bound to be repercussions in the others. The commoner reasons for referral are those which are more of a nuisance to the grown-ups, as some adult has to consider the child a problem before it is referred. "Naughty" children are sent more readily than timid children. The larger the class at school, the greater the chance of referral. The staffing and siting of the clinic or centre also influences the type of referral. At a children's hospital, enuretics, asthmas, feeding problems, will predominate. At a psychological centre, backwardness, day-dreaming, stealing, destructiveness will be more prevalent.

From the above cases it is easily realized that much child guidance is, in fact, parent guidance. As a rough-and-ready rule one may say that with the under-fives three-quarters of the work is with the parents; from five to eleven it is fifty-fifty; over the age of eleven it is the work with the child that is of greater importance.

Treatment has to be considered from the two sides, parent and child. Once again one has to stress the fact that treatment of fathers is, in most clinics, conspicuous by its absence. Treatment of mothers may be in part educational and suggestive, and in part cathartic. The former deals chiefly with the child, methods of meeting and avoiding problems, explaining what is usual at certain ages, that independence, prized by adults, is uncommonly like obstinacy when at work in the nursery. The latter is more truly psychotherapeutic, if anyone feels frustrated, tense or inhibited, they are less able to give affection and they are more likely to give vent to other feelings when checked or irritated by a, to them, less overpowering member of society;

the clerk told off by his employer, takes it out on the office boy ; the daughter frustrated by her own mother is likely to expect too much of her own child. Friction between parents makes for nail-biting among their children. If a mother will unburden herself, and the greater the feeling, the greater the relief, then she is able to return to her home better able to cope with her children and the everyday problems of life.

Owing to a child's limited vocabulary and lack of understanding of abstract ideas, discussion plays little part in treatment, instead one makes use of the child's natural form of self-expression—play. In suitable cases play-therapy may be combined with other measures such as medicine, speech-therapy or specific tuition. To the grown-up, play is apt to signify something unimportant, a way of idling away the time, but to the child it is real work and is as expressive of the individual as any other form of creative work. A bedroom or study can tell us much about the owner, so the play-world can reveal to us a great deal about the child. How a child plays, his selection of toys, impulsive or thoughtful, the actual things chosen, their arrangement, what happens to them during the play, is of significance. There is the child who never gets down to actual play but spends the whole session arranging the pieces, the child who never chooses people but only animals. When arranging a battle, one boy will divide the soldiers equally, an insecure lad will see that he has the larger force. The way the "dangerous" things, crocodiles, guns, soldiers, face, whether towards the child or away, is of importance. One notes whether the wild animals are carefully fenced in or whether they roam at large. Then the fate which overtakes the toys, the male figure who is always being run over, the child who gets accidentally (?) buried, may show one the emotional problems that are occupying the child's mind.

The commoner problems are excessive aggression or drive for power ; a feeling of guilt or sense of inferiority, usually the consequence of past aggression felt or put into practice ; lack of affection by parents, with resultant insecurity and inability to love others. Needless to say the child has no insight into his problems, he quite fails to appreciate that his dawdling over meals is one way of getting more attention from mother.

If the problem is at a more primitive level, then play is more elementary, sand, water, squirting water into holes, making a mess, letting the water get on the floor (and watching the adults' reaction). Hammering, cutting, sawing, can all help a child who is uncertain as to how much scope may be given to his destructive impulses.

Older children can use puppets or dressing-up games to act out their feelings.

Play-therapy is by no means standardized. Some therapists think it wisest to act merely as passive observers, although even by their presence and non-interference they must be classed as beneficent grown-ups. Others take a more active role. Most

consider that at some stage the problems must be allowed to enter consciousness, that the aggression and fears should be linked to the objects causing them. At present, most play-therapists are self-taught, or, at best, have watched other play-therapists at work, but the need for a more definite type of training is recognized. The emotions of a child are not lightly to be played with, the potential aggression is great and if proper channels are not provided then the destructive effect may be much greater than expected. Provided the personality is stable and the individual has insight into his own problems and is willing to proceed slowly then probably any member of the team can develop into an efficient therapist. The training of the mental hospital psychiatrist in this respect gives him little advantage over that of the educational psychologist, neither of them has had specific training in emotional problems while both of them may have made full use of their practical experience and learned from it, the same applies equally to the psychiatric social worker.

Treatment occasionally requires residence away from home, but at present, adequate in-patient accommodation in colony, hospital, or hostel, is extremely limited. Even facilities for residential observation are practically non-existent. Prior to the war there was a flourishing register of foster-homes, but lack of houses, the general strain of queues and post-war shopping, together with the experiences of war-time billeting, has caused a dearth of willing foster-mothers.

One should not lose sight of the fact that the child is developing and that a proper "leading forth" (e-duco) of his assets may be as important as the solving of his problem. For this reason seeing a child at the same hour each week may be a mistake, if as a result, he always misses the same class.

Child guidance is an expanding subject and certain aspects of it are receiving special attention at present. At the organic level studies with the electro-encephalogram show that in certain children their "physiological age", to coin a phrase, lags behind their chronological age, the records are atypical for their age though possibly within normal limits for a younger child. The certainty regarding the intelligence quotient is much less than it used to be, it is still true that the intelligence quotient is fixed "provided the child is doing its best", but temperamental factors which influence the result are now receiving an attention that they seldom had before. Various attempts are being made to estimate the "emotional age" of the child. One speaks also now of "social quotients", this being the ratio of the child's social achievement compared with his chronological age. Vocational guidance is a new service which will expand greatly once it is better standardized. Group Therapy is being investigated. It is no new thing for a therapist to take one or two children together, often partly to save time, it also provides a chance of seeing difficult children playing together, but now it is coming into its own as a specific form of therapy.

So much for the plan ; in fact, however, the tale is at present rather different. There are many areas without clinics, of those open many cannot get fully trained workers for each department. Waiting lists are long and the number of unwanted children does not grow shorter. Every clinic has its group of post-evacuation cases where the child has had no settled home but lived in a series of hostels. It is therefore of increasing importance that as much preventive work be done as early

as possible, that screening be as efficient as possible. Educational psychologists, school medical officers, paediatricians, social workers are the first line of defence. Their training should enable them to deal with simpler problems but in every case a follow-up should be made after six months, and if the improvement is not maintained then the case should be sent on for fuller exploration and treatment. Only in this way can the best use be made of the limited services available at present.

## Juvenile Delinquency\*

By J. D. W. PEARCE, M.A., M.D., F.R.C.P.E., D.P.M.

*Co-Director, Institute for the Scientific Treatment of Delinquency; Hon. Psychiatrist, Queen Elizabeth Hospital for Children; Hon. Physician, Tavistock Clinic*

Delinquency is not in itself a disease but is only an indication of some mental variation in the individual. That delinquency occurs means more than simply something the matter with the individual ; it signifies also some malady of society. There is a tendency among some workers to regard social conditions as embracing the whole causation, but to adopt such a point of view is to be in error. There are nearly always several causal factors, as almost any delinquency points to a problem, both in the individual and in the environment in which he lives. There are many ways in which the psychiatric social worker is able to help in the treatment of delinquent situations and in the prevention of their development ; in fact, her greater opportunity is perhaps in the latter field. All psychiatric social workers in their day-to-day work deal with family situations which may very well lead to delinquency in one or other of the children.

The main varieties of delinquent conduct are sexual misconduct, acts of aggression, stealing, truancy from school and running away from home. Each case presents an individual and unique problem and must be approached as such.

The great majority of delinquents come from the slums. The social factors are protean, and, as such conditioning circumstances are beyond the control of the child and originate in defects of society, there is a danger of assuming that the child himself is hardly part of the problem. However, only a minority of the children who are exposed to such stresses do in fact become delinquent. With delinquency as with many other medical problems it is often far less important to know just what is the nature of the disturbed behaviour or of the disease process than it is to recognize just what kind of person is afflicted thereby. It is only by such a comprehensive approach to the problem that any success in remedial or preventive measures will be achieved. As a corrective to any tendency

to attribute all delinquency to environmental factors it is well to recall the work of Healy and Bronner. These workers made a comparative study of a series of delinquent children and their non-delinquent siblings. One cannot do better than quote the following from their report :

" Unsatisfying human relationships form obstructions to the flow of normal urges, desires and wishes in the channels of socially acceptable activities. The deflected current of feelings of being inadequate, deprived or thwarted in ego or love satisfactions, turns strongly into urges for substitutive satisfactions. The obstructive relationships are mainly those within the family group where the attitudes and behaviour of parents and others are influenced by their own personal dissatisfactions. Ideas of delinquency are derived from companions, the observation of special temptations, reading, etc. These sources of ideas constitute environmental pressures. Through the acceptance of such ideas, the deflected portion of the current of feelings and activities finds expression in delinquency. Underlying all these are current attitudes, beliefs, local and group ideologies—the ideas and practices of asocial individualism. These in turn are stimulated by local conditions and by early observed exploitations, unfairnesses or dishonesties in business, law, politics, officialdom."

Healy and Bronner also stress the fact that ethical concepts which have no personification have little force in the lives of young people. Such personification is dependent on the emotional tie-up with the parents and where this is inadequate the character tends to be ill-developed. As one digests the full implication of these conclusions by Healy and Bronner—and it is to be remembered that they are based on very careful and controlled observation and research—the scope for valuable work by social workers will become quite obvious to the reader. The psychiatric social worker in her routine social surveys will, if she has the eyes

\* Our fourth article on special problems.—Ed.

with which to see, come across many situations in which one or other child in a family is subject to just such frustrations, the ultimate response to which may very well be delinquency, which in itself may sometimes end in a persistently anti-social, criminal character and personality. Though the whole problem at times seems so vast that one may feel somewhat overwhelmed by it, every individual action taken to relieve such miseries is well worth while.

A more detailed discussion of the social factors significant in delinquency can now be made. Dr. Emanuel Miller classifies gross environmental anomalies as follows :

- (1) Delinquent "habits" of a group.
- (2) Economic and social degradation.
- (3) Change of mores—evacuation and immigration and failure to adapt.
- (4) Educational environment unsuited to certain dullards, superiors, and neurotic types.
- (5) Developmental, psychically-abnormal patterns due to gross disturbances of parent-child relationships, etc.

Ire S. Wile considered maladjustments in the happiness and behaviour of children to have grown out of customs, laws, regulations and ordinances, rather than wholly out of ignorance, misunderstanding and inherent frailties. In his view the main general sociological causes fall under the three headings of social sanction, social tolerance and social indifference. I think the reader will agree that though differently expressed these two writers are very much in accord in this matter, and that simply to amend a variety of specific faults in the social setting without considering the underlying basic social defects is much the same as treating symptoms in sick persons rather than attacking the basic disease processes. This does not mean that it is not useful and indeed essential to deal with those specific environmental stresses in each case ; in fact it is often very important to do so ; but if the incidence of delinquency is to be reduced it is necessary also to deal with the larger underlying causes.

In investigating specific environmental factors and their significance in delinquency it is best to begin with the home life and to work outwards from this. With delinquents it is much more common to find a broken home than with non-delinquents. All too often it is the internal family situation which is seriously at fault, e.g. divorce, desertion, step-parents, illegitimacy, cruelty, defective discipline and example, war separation and war reunion. Poverty is also very prevalent, causing overcrowding and hence sexual temptations ; and hunger which leads to other temptations ; and lack of opportunities for play and other outlets for the normal energy of the child, leading in some cases to compensatory gratification in delinquency.

The neighbourhood may be a major factor. Certain districts are much more heavily loaded with delinquency than others. Such districts are

those in which there is much opportunity of contact with vulgarity, vice and crime ; where bad companions and evil example abound ; where no recreational facilities exist ; where temptations such as pin-table saloons and the display of attractive but honestly unobtainable goods abound. Another factor in some districts is the current phenomenon of the landlord who will have children in his so-called furnished rooms only under protest. Such landlords insist that children must be kept entirely quiet, failing which the family will be evicted. In a case recently dealt with a mother had to take her child, not more than three years old, out of the house every day before 8.30 in the morning, and she was not allowed to return until six o'clock at night. The alternative was eviction. This is not an isolated case. A series of cases have been seen in which the children have to bottle-up all their natural energy and to keep quite quiet all day long, resulting in a variety of serious psychiatric reactions. They are not allowed to run about in the house, and in fact in many cases boots have to be removed in order to insure quiet, the constant threat hanging over the parents being eviction.

Many difficulties arise in school life and the common situations requiring exploration are the personal relationships with the teachers and the other children, and the success or otherwise which the child has with his school work. The other common miseries of school life are all too frequent among delinquent children ; a common example is inferior clothing. Most children who play truant are either unhappy or bored at school. Non-co-operation of parents with teachers is not unknown, and the psychiatric social worker can do a very great deal to improve such relationships.

Many delinquents have as a background a bad employment record, having too often got into dead-end jobs with all their resultant frustration. The attitude of many delinquents towards hard work is often very poor and at the present time this is linked up with the fact that during the war years many youngsters were able to earn very high wages in return for very little service. In some cases their attitude to dishonesty and slackness is not helped by the employers who, when adolescent employees embezzle funds, e.g. the message boy who collects money as he goes on his rounds—do not bother to take any action about it. One must not condemn such employers out of hand, as to take action may very well mean a serious loss of time on the part of the employer, who frequently has to spend one or two days in Court, for which he gets no compensation. Employers often feel that the loss of a pound or two is a smaller hardship than the dislocation of their work by the loss of so much time. Nevertheless, such failure to discharge their social responsibilities is to be deplored. The black market too provides much temptation for children, who are enticed into it by adult operators. This applies to a large number of delinquents, and constitutes a real social problem.

The rapid decline in religious training and

religious interest inevitably means a less healthy conscience. In many delinquents it is very common to find an almost total lack of any religious knowledge, interest, or belief. When one comes to consider the attitude of society in practice to law-breaking, birth control, and illicit sexual relationships, as is so clearly apparent in certain sections of the press and entertainment world, one cannot but conclude that such attitudes exercise an adverse influence over the development of socially healthy consciences.

This admittedly superficial survey of social factors commonly involved is by no means complete, and many other instances of conditions and attitudes in and of the community will occur to the reader.

In considering the problem of delinquency it is at least equally important also to study the children who become delinquent. Juvenile delinquents are in many ways relatively inferior to their non-delinquent brethren. This inferiority may be physical or intellectual and sometimes both. Frequently it is slight but none the less significant. Inferiorities are sometimes constitutional, but perhaps usually the result of faulty nurture. Such faulty nurture is in itself due to various social deficiencies. Examples of such physical inferiorities are poor bodily development often complicated by old rickets, and specific defects such as poor sight and hardness of hearing. Intellectually delinquents by and large are of lower intelligence than non-delinquents. Many delinquents also appear constitutionally to lack stability of temperament. Such disability prevents the person affected from being able to compete on equal terms with his better endowed or better developed rivals. The ways in which such a principle can work in human relationships and activities may profitably be left to the reader to tease out for himself. Certain classic types of reaction to any such disability are that it may be regarded by its possessor as something calling for compensation; or as a reason for giving up altogether in face of difficulties; or as a useful attribute which can be exploited. Some of the ways in which delinquency can be the product of such a situation will be apparent to every psychiatric social worker.

In each case it is essential to make a careful physical survey of the child, not only to determine if any disease processes are present, but also to assess the functional capacity of the individual. Similarly, one cannot get far in any problem of delinquency without knowing the level of intelligence and of educational attainment of the child in trouble. It is well to remember that an important though very small group of cases of disturbed conduct are the direct result of physical disease, such as encephalitis lethargica and epilepsy; though the presence of the latter in any case does not mean that it is necessarily the main cause. It is important to keep one's eyes open for possible mental deficiency, as all too frequently this condition is for the first time discovered only after a considerable career of crime. Where mental deficiency is

pronounced, it will probably over-rule all the other causal factors with regard to disposal.

In the final analysis delinquency does seem to be dependent on a trait of character, and unless this delinquent trait of character can be modified the conduct will not change. It is useful therefore to view delinquency as due to a trait of character which may be the result of various circumstances. One important trait is that which is dependent essentially on a state of mental deficiency, and the treatment will be that of mental deficiency. For example, many a child plays truant from school and then gets into all kinds of secondary delinquent habits because, being mentally deficient, he cannot understand or enjoy his work. The proper treatment may then be classification as educationally sub-normal under the Education Act of 1944 whereby he will receive suitable education either at a special day school, or, if other conditions point to it, in a special residential school for such children. Very often with such treatment the delinquent trait of character disappears.

In quite a large number of cases the delinquent trait of character develops because of the child's instability of temperament; this is often referred to as a temperamental character trait. The very fact that this is the main underlying cause of the delinquency will suggest to the social worker the lines of treatment necessary. It will also be obvious that no sudden or dramatic result from treatment can be looked for in such cases. One has to rely mainly on prolonged careful training and re-education, often supported by a considerable measure of external supervision and control. Such cases may require to be bolstered up for many years to come. The classic example of this is the boy or girl who gets into trouble time and time again and who seems to be unable to learn from experience or to look ahead, qualities typical of the psychopathic personality. Many such children end up in approved schools where they often behave fairly well and get along all right. Far too often, however, on being set loose in the world without continued supervision and guidance these individuals quickly relapse into delinquency. This particular group, as all psychiatric social workers well know, constitutes one of the large problems confronting society. It does look as if special provision will have to be made for the proper supervision and control of such persons. It should be observed that punishment is unlikely to have any prolonged deterrent effect on such individuals.

A third delinquent character trait develops from the influences of the environment, e.g. bad companions leading a child into bad habits. It is in this third group of cases that there lies the main scope for sharp disciplinary punishment, and one's personal point of view is that corporal punishment administered by the child's parents or by the school teacher may be a useful remedy. Sometimes a short separation from home which is clearly recognized by the child as a punishment, or the application of the principle of restitution will be effective. It

is important also to provide such children with really good alternative social outlets ; such measures as club membership and adequate recreational facilities are helpful. In this particular group the imaginative psychiatric social worker can play a very useful part.

In those cases where the trait of character is the direct or indirect outcome of some organic disease, the treatment is obviously that of the latter, of which the conduct disorder is only a symptom.

Another important variety is known as the reaction character trait. In these cases the person acquires a delinquent anti-social character as a result of suppressing the opposite tendency. An example of this is where a child who is denied affection and love so persistently and severely that he gets to the point when he cannot stand such deprivation any longer, will react to this by putting all thought of it out of his conscious mind and by becoming independent and self-sufficient. In order to keep the unsatisfied tendency properly suppressed he has to maintain this attitude of independence ; hence it is very persistent and rather overdone. He becomes hostile to everyone and very much against all law and order. Such persons have little or no feeling for others ; they are lonely and up against the world. Their anti-social character is very apparent to the community as is only to be expected with such a mental mechanism ; and they have no conscience with regard to what they do. Once this transformation has taken place it is very difficult or even impossible to reverse it. In order to react to early adversity in so strong a fashion, these persons require to have a certain robustness of temperament which, had it only been canalized in socially useful ways, would have made them into really good citizens with considerable qualities of leadership. They are also usually of good intelligence. The psychiatric social worker will come across many children exposed to just the kind of deprivation which may be the stimulus for the development of this particular type of reaction. If such cases are encountered it is most important to take steps to correct the unfortunate family situation or to provide opportunities for substitute gratification of the thwarted tendency, usually the need for affection. In this way the hard core of persistent, clever, adult criminals will be reduced. A classic instance of this would be the following. A school boy is not only unloved but actually despised and hated by his father. There is a younger brother who is the apple of father's eye. Father's hatred is carried to the extent of severely thrashing the boy at least once a week as a routine. The boy for some years does his utmost to win father's regard, but gradually becomes discouraged and, after going through a phase of despondency and suppressing his yearnings for parental affection, turns not only against his parents but against all figures of authority. He may then start stealing cars and get into trouble with the police. Gradually he may become more and more delinquent in his conduct, and may end up in Court on some

charge of a very grave type, such as armed robbery, coupled with rape. The importance of the mental mechanism underlying many such histories as this indicates the need to identify such situations in the early stages. Unhappily, by the time they reach the hands of the psychiatrist these people are on a par with so many cases of cancer coming to the surgeon in that they are beyond any treatment. The best one can do very often is to provide prolonged training and re-education as in Borstal ; but unless someone succeeds in winning the affection and devotion of the sufferer, for such he is, all this is of little avail. In some cases the old suppressed longing will emerge into the person's awareness to the extent of his becoming, for no reason known to himself, very melancholy and depressed. That some such persons commit suicide is not to be wondered at.

Another important trait of character is known as a psycho-neurotic character trait. In such cases the mental mechanism at work is that of a psycho-neurosis and the delinquency is due to the emergence of what is repressed. The outstanding feature of such cases is that the disturbed conduct is quite foreign to the normal day-to-day character and personality of the individual. The classic example is the best pupil in the school who is detected stealing from his teacher or from the other children. Very often the delinquency seems to be without any immediately useful purpose, and indeed it may be so designed that detection is inevitable and punishment ensues. These are the cases in which psychotherapy is the correct treatment. It is by dealing with and clearing up the psycho-neurosis that the conduct disturbance will disappear and the unconscious delinquent trait of character be eradicated.

Finally, there is what is called a psychotic character trait. In these cases the delinquent person is suffering from a psychosis, usually schizophrenia, and his usual conduct is only a part of his disordered mental state. Treatment is obviously that of the psychosis. This is a small group but one in which the experience of the psychiatric social worker, who may be the first trained person to meet the case, will be very helpful as the sooner identified the sooner remedied.

When one considers the practical measures which one can employ in dealing with delinquent persons, one quickly finds that they are rather limited in scope. The Juvenile Court can make a variety of disposals. For example the Court can place an accused person on probation, and this in many cases is sufficient. The work of the probation officer and the psychiatric social worker overlap to some extent, and the more they co-operate and get to know one another the more fruitful will be their measures in dealing with their case material. The whole range of residential disposal with the Courts can apply, from foster homes and approved hostels to Home Office schools and Borstal, have their uses in different cases.

The psychiatric social worker may find it necessary occasionally to advise parents to bring a child

before the Juvenile Court as being "beyond control". This is reserved, of course, only for cases where the situation cannot really be satisfactorily resolved without recourse to the Court. The enlightened magistrate may then be able to order the type of disposal required. To deal with all the weapons which the Court has at hand would occupy far too much space, and in any case the social worker will discover all she needs to find out about these matters if only she will make the necessary contact with the probation Officers in her district.

The Education Act of 1944 has also improved the facilities for the adequate treatment of some of these conditions. In particular, the class of problem child known as the "maladjusted pupil" has been recognized. Provision for special hostels at which such children can reside and have the necessary psychiatric treatment is made in the Act, though many local authorities have been rather slow to do anything about this.

Perhaps the main outstanding problem for which practically nothing has yet been done is that of the large group of psychopathic persons, i.e. the temperamental character trait cases, a problem which has not yet even been fully thought out, and certainly for which there is as yet but little adequate constructive provision. In their work psychiatric social workers will have many opportunities of urging forward the growing edge of public opinion and interest in this as in other social problems.

The local telephone directory will usually give the address of the probation officers under the heading of Probation Service. The probation officer has in his possession all the information about special hostels, clubs and other facilities. The Institute for the Scientific Treatment of Delinquency, 8 Bourdon Street, Davies Street, London, W.I., has carried out much research into various problems of delinquency and is a useful source of information on any problems related with this field of work.

## "... And Nobody Cares for me!"

By EDWARD LIGHTOWLER

*Headmaster, Joseph Rowntree School, New Earswick, York*

Jimmy W. is an agreeable enough boy with a disarming smile and a natural gentleness of manner toward those who have not his unusual physical strength. He was admitted to my school in late 1944 and I soon learned that he came from Sunderland, had proved a headache to those in authority over him, was aged between thirteen and fourteen, and had no particular aim in life except to get back to Sunderland and, in his words, "do for" his stepfather. This may have been a quite laudable ambition, I don't know, I never met the stepfather. At the same time it was quite clear that society would not approve and that Jimmy must, in some way, be brought to see that there are other aims in life. But, before going further, perhaps a few words about the school and Jimmy's place in it may not come amiss.

Secondary Modern in type, and built jointly by the North Riding of Yorkshire Local Education Authority and the Joseph Rowntree Village Trust, the school was opened in 1942 by the Right Hon. R. A. Butler, M.P., then President of the Board. The Trust's connection with it has enabled the school to undertake some work of an experimental nature including exploration of the possibilities of handicraft as a factor in the education of non-academic boys, the workshop is unusually well equipped. There is also a good garden and a pleasant area of park-land surrounds the building. The children, approximately 400 boys and girls over the age of eleven, come from numerous quiet villages to the North-east of York and from New Earswick in

which the school stands. The last named is somewhat different from the other, older villages. It has been built entirely in this century as a "model village", it has a very good primary school, its social standards are unusually high and it lies only just outside the city boundary.

In one of the villages was a small hostel for difficult evacuees. We had no contact with them as all those attending were educated together as an isolated colony. Most people regarded them with a mixture of curiosity and suspicion and if, in the village where they lived, any petty theft took place or windows were broken it was convenient to put the blame upon them. Sometimes they were guilty but not always so.

In the summer of 1944 the local authority took a very courageous and, as it now appears, a very wise decision, although most of us at the time had grave misgivings. It was decided that all boys at the hostel should, on reaching the age of 11 plus, be transferred to this school. Ten boys were to arrive at the start of the new term in September. Parents protested, the School Governors were, not unnaturally, perturbed as were the staff and myself. But, as there seemed to be no sign of any reversal of the decision I turned to my books to find what others had to say and was cheered to find that Lane, Duncan, Neill, and other pioneers all agreed on one point—children branded as backward and/or difficult were scarcely ever as bad as one expected them to be. The reports on the boys included such passages as—"Dirty habits at the

table". "Slashes the table-cloth with a razor blade." "Hysterical in billet," etc., and viewed against the general background of the school, the prospect seemed unpleasant. As a staff we had all kinds of queries—should we keep them in one group, should we allow any contact with the girls, should we put them all at one table for lunch, and what about those razor blades? We were more than a little worried and I decided to visit the hostel.

That visit was most enlightening. The boys were at play in the grounds. Attempts at conversation they regarded with suspicion but, eventually, one boy showed me his rabbits with some pride. I was suitably impressed and he then went on to show me his garden. Thus encouraged two other boys showed me their gardens after which, one, greatly daring, asked me if I would care to see his "home". This puzzled me, but I followed his lead down some roughly cut steps into a large hole in the ground. The hole had been roofed over with old timbers, tin, linoleum, and finally with turf. Inside it was clean and tidy. The walls were decorated with magazine pictures, all manner of boyish treasures were fastened up in a box, there was a rough seat. After this surprise I saw several more homes, almost every boy had one, no two were alike. Their craving for security, love, protection, all that "home" means to the normal child was distressingly obvious and I began to get a glimmering of the wisdom behind the decision to send them to a normal school to mix with other, more fortunate, children. Later I was to reach the conclusion that hostel life can never replace home life and that, wherever possible, a foster-parent should be found.

A week later the boys arrived, being accompanied by the warden of the hostel. He also paid in their dinner money and arranged to collect them. They seemed quiet, abashed, fearful of what might be about to happen. What did actually happen was that the head boy took them around the school, allowing them to dally wherever they wished. The other children knew about them, of course, from their parents, but had been asked to treat them as ordinary, normal, new boys. Later, the boys all came to my office, two were aged 11, six were 12, one was 13 and one 14 years of age. Following up a line decided at a staff conference I welcomed them to the school and told them they would be treated as normal boys in every way. They would be placed in suitable forms, drafted into school houses, allowed to sit where they pleased at lunch and not be watched in any special way. We would try to make their time in school both profitable and enjoyable but, if they wanted to run away, the doors were always open and we were all, really, far too busy to be always watching to see they didn't go, at the same time we should think they were babies if they did. The whole group then went to the workshop to carry out pre-arranged tasks the while each boy had an interview of a more personal kind. Each was told of his record,

nothing was concealed, the whole sorry story was laid bare, forgiven and forgotten and the boy told that, from that moment onward, the record ceased to exist except as a personal secret between himself and me, it would not be considered further and he started again from scratch. Any special favours would be considered sympathetically, materials or tools wanted for work at the hostel would be loaned, there would be no need at all to steal them but, having made all this clear, it was also made clear that the reverse also held good. All children in the school were subject to school discipline and rules were meant to be kept by them as by everyone else without exception or favour, the only special dispensation to be given was that, as they had no parents to turn to, we would all be glad to advise whenever any boy found himself in difficulty. The approach was personal and varied a little with the boy, of course, some had no record of delinquency, the trouble being emotional, due to anxiety complex, etc., but every single one had a history of difficulties in behaviour. Next they were given various tests, their intelligence quotients were ascertained (two of under 70, three between 70 and 80, three between 80 and 90, and two between 90 and 100) and they were placed in suitable forms.

From the first the arrangements worked well. Their suspicion and hostility eased gradually and so did our fears. The workshop was their Mecca, although Gardening and Physical Education were also popular, they welcomed any opportunity for indulging in useful and creative work, they ceased to band together and played normally with other boys, one took a part in a school play. Of their conduct in the dining room we never had to complain, either they had been well taught before we got them or their records were sadly wrong. The razor blades became a joke, they never showed any viciousness, in fact it all seems, looking back, to have been too easy. Very soon afterwards they were complimented on playing up to our trust in them, told that the warden would now cease to accompany them, told that each would be required to bring and pay in his own dinner money and sent away rejoicing. From that day on everyone ceased to regard them as being in any way unusual. Before the hostel closed in February, 1947, we had passed 28 boys through the school and not one caused us any real worry, although one of them, Douglas C., was a bit of a nuisance. He used to follow first me and, later, other members of the staff around, while enquiring plaintively if we had a job for him, which would help us. We had quite a time inventing tasks to satisfy his craving to express his gratitude.

Only this week one of them wrote to me, he was classed as "noisy, hysterical, moody, highly strung, very frightened in raids, shows violent temper, sister, M.D." May I quote from his letter? "Just a few lines to let you know I have not forgotten you or the school I used to attend. I think you know I am in an approved school because you sent

me a good record to A., but *do not think I have been stealing*" (what anxious pride is in that sentence!—E.L.). "When I left the hostel I went back to Hull because my Mother claimed me. When I was two weeks old my Mother left me to her twin sister and she then left me to her husband's mother, *nobody wanted me*. I lived with her until I was eight and then war broke out and I was evacuated and in 1946 went to the hostel and attended your school. All that time I had never heard of my Mother until 1946 and then I had to leave the hostel

and go back to her. I did not like her so I ran away. Altogether I ran away three times but now I find myself in a school again." The story in that letter is too clear to need comment. Unloved, unwanted, insecure, these boys craved a home and all that the word implies and the school helped to give them something of what they wanted. Outcasts and pariahs they craved the opportunity to prove they could be useful members of a community. There is no need to dwell upon the lessons to be learned from the experiment.

## National Health Service Act, 1946

### Local Authorities' Schemes for a Mental Health Service

Under Section 20 (2) of the National Health Service Act, Local Authorities are required to serve copies of their Schemes for carrying out the duties imposed on them, to every voluntary organization providing in their areas services of the kind concerned. Copies of the Schemes dealing with the Mental Health Service (Sections 28 and 51) were therefore submitted to the National Association for Mental Health, and have been closely examined by the Association's officers and staff. Observations were then sent to the Minister, at his request. The chief points on which comment was made are here summarized.

#### 1. Medical Personnel

The majority of the Schemes propose that the Medical Officer of Health should be responsible for the general direction of the Mental Health Services with the part-time help of Assistant Medical Officers who have taken a short course in Mental Deficiency, and general practitioners approved as Certifying Officers. In addition, joint-user arrangements with the Regional Hospital Boards' psychiatrists are proposed, when decisions have to be made on doubtful and difficult cases. The Association urges the use of psychiatrists in a wider consultative capacity and particularly for supervising social case work. Such a provision is stressed as being of the utmost importance in view of the fact that Local Authorities must at present be dependent for such case work largely on a non-medical staff often with little or no specialized mental health training or experience.

#### 2. Non-Medical Personnel

The use of psychiatric social workers, general social workers, mental welfare officers with mental deficiency experience, Public Assistance Officers and Health Visitors is indicated in the Schemes under this heading, but it is evident that the majority

of Local Authorities have little understanding of the functions properly belonging to each group. Nor is there any adequate appreciation of the distinction between *administrative* work and social work concerned with individual cases.

The Association fully recognizes that under present conditions, authorities cannot hope to secure fully trained personnel to cover the whole field, but it is suggested that an effort should at least be made to employ as the head of the team, an experienced Mental Health worker (if a psychiatric social worker cannot be obtained).

#### 3. Mental Deficiency Work

For the supervision of mental defectives, on which a variety of personnel is to be used, it is urged that the Minister should take steps to ensure that Local Authorities are aware of the need for some special training in order that the requirements of this group may be fully understood. Many authorities propose to establish, or increase the number of Occupation Centres, and attention is drawn by the Association to the Year's Training Course for Occupation Centre workers for which early application should be made.

#### 4. Community Care and After-Care of persons suffering from mental illness, including neurotics, socially maladjusted and epileptics (Section 28)

Only a few progressive authorities are proposing to take any immediate steps under this Section, in so far as it relates to the neurotic and socially maladjusted group. In view, however, of the shortage of the necessary trained personnel, and of the proportions which this work rapidly assumes once it is begun, the Association is of opinion that no purpose would be served by pressing for its development at the present time. It is nevertheless important for authorities to realize that the need exists and that it is waiting to be met.

### 5. Training of Personnel for the Mental Health Service

The attention of the Minister is called to the Courses for Relieving Officers transferred to the Mental Health Service, which are being organized by the National Association (see page 101) and it is suggested that Local Authorities should be encouraged to explore the possibilities of such courses in their own areas.

### 6. Mental Health Education

Only a minority of Schemes mention Health Education and of these a minority again refer to education in *mental health*. The attention of the Minister is drawn to the importance of this aspect of the subject and to the facilities offered by the National Association as well as by the Central Council for Health Education.

## The International Congress on Mental Health

London, 11th to 21st August, 1948

At the time of writing, final reports from well over two hundred Preparatory Commissions in nearly twenty countries are pouring into the London Office. These are being grouped under the most appropriate subject, and when this classification is complete, a team of editors from the Central Commissions and elsewhere will produce an integrated document on each subject. These documents and the originals will be used by the International Preparatory Commission, which will meet in residence near London for a fortnight shortly before the Congress. After intensive study and discussion, the International Preparatory Commission will prepare statements which will form the basis of discussion at the Congress.

It is as yet too early to say anything of the lasting value of the reports which have come in, but whatever their quality, there is no doubt that the Commissions themselves have found that discussion between members of kindred professions is an extremely worthwhile experience. The comments of the members on the difficulties they have encountered and the ways in which they have worked through them to the point at which they were able to start co-operation, provide most interesting reading. Those who have themselves taken part in Preparatory Commissions and wish to add any such comments to their reports, may be sure that they will be studied with great care.

Many Conveners have expressed gratitude for the impetus provided by the Congress in getting

them to the point of starting work which otherwise might not have been undertaken. It is clear that many Commissions will continue their work long after the Congress is over, and that in some instances, the informal study begun for the Congress will result in long-term research.

On the administrative side arrangements for the Congress are also taking shape. At least fifteen hundred members are expected to attend; about half of these are from the United Kingdom and half from forty different overseas countries. In addition to the daily plenary sessions of the Congress and the specialist meetings and study groups which are being planned, there will be various "sidelines," such as a comprehensive display of books and exhibits from various countries, and a continuous performance of documentary films on topics relating to the subjects under discussion.

Accommodation is one of the worst problems. Many members will be coming from war damaged countries where currency difficulties will make it almost impossible for them to meet their own expenses. Offers of hospitality in the London area, or donations, however small, towards the cost of providing accommodation will, therefore, be most welcome.

A number of volunteers are offering to act as stewards, ushers and liaison officers (if they know languages) and the Congress office would be glad to hear of anyone, not qualified to attend the Congress as a member, who might care to help in this way.

**Wanted.** Superintendent for The Old Rectory, Bathwick Hill, Bath—a Hostel for 24 high-grade mentally defective girls.

Salary : £250 rising to £300.

Applications to be addressed to : Miss Tillard, Church Farm, Bathford, Somerset.

## How can the Mental Nurse Contribute to the Recovery of the Depressed Patient ?

By JOAN EVANS

*Staff Nurse, Hayes Park Nursing Home*

Winner "Lord" Memorial Essay Competition Prize, 1947

The doctor gives his orders—the nurse carries them out, but it is the way in which they are carried out, with all the considerations a nurse can give, which contribute to recovery.

Firstly, most mental patients are physically as well as mentally ill and the points to consider are : rest, nourishment, careful supervision and occupation.

From the time of admission the cause of the depression must be ascertained, as this may save the patient from a great deal of distress by avoiding a subject which brings back memories which are best forgotten. This will depend on the ability of the nurse to get into contact with the patient's mind. To do this, she must be interested enough to learn facts about the patient, her ordinary life and surroundings, and to make the patient feel that she is talking as one human being to another.

Admission to a patient is a very bewildering time. To put one at her ease, explain that it is routine and will soon be over. But it is an excellent time to ask the patient a few questions, and you will be able to tell whether conversation is going to be difficult. If the patient is being admitted to a room, endeavour to have fresh flowers there and, if cold weather, a hot bottle in the bed—don't let it be a day that is looked back on with dread, but one—when recovery comes along—that is remembered as not so terrible after all.

A patient is sometimes reluctant to go to bed, but by tact this will be accomplished—then take a cup of tea along and allow the relatives in to see the patient for a few minutes before leaving, and assure the patient that recovery will not be long—although with this type of illness it sometimes takes a little while—and that by carrying out all she is asked to do not only will she help herself, but also help her relatives to realize that everything possible will be done for her and relieve their anxiety. If it is possible for a nurse to remain with the patient on the first day, so much the better. This is possible in a ward, but in a private room more difficult, but it really is necessary, as the nurse can study the patient's reactions and observe anything of importance. Some are very difficult in settling down to rest for a few days—concentration will be lacking so don't give books to read ; take along a few magazines—something that does not need deep thought. The nurse who can forget herself

and think first of the patient is invaluable—generosity will react on her behaviour and help recovery more than anything else. There must never be any display of sentiment, and authority must never be abandoned ; there must be an attitude which will inspire the patient with trust, confidence and the hope needed.

With the depressed client meals are sometimes a difficulty—refusal of food so often being made. Now it is very important to serve meals attractively find out the patient's likes and dislikes and never serve large portions—more can be asked for, whereas a plate overfilled will probably turn the patient from the meal altogether. If there is complete refusal of food, see if a tonic could be given before meals, and if this has no effect explain that she is under your care and you cannot let her go without meals ; explain that this will have to be reported to the doctor who, if he thinks necessary, will resort to other methods and a little feed by a tube will be given. Don't alarm the patient, but just explain as simply as can be about this, and by great tact the patient will realize how foolish it is not to eat, and will like her food. But, on the other hand, some patients will think they know better and will find some reason for not doing what is asked ; it is a good plan then to try and strike a bargain and give in to her in small matters as, may be, a different arrangement of the food tray or any similar details regarding meals ; it is also perhaps a good plan to refer such matters to the doctor in the presence of the patient so that she knows exactly the doctor's decision on the matter.

Strict supervision is sometimes needed, depressed patients being treated, at first anyway, as potential suicides. If this is necessary, it must be carried out in such a way that the patient will not feel she is always being watched. The nurse can—if in a ward—always be on duty there doing various jobs about the ward ; if a private room, suggest that patients are always with a nurse for a few days so as not to feel lonely, suggest that you do some mending for the patient, or perhaps take in a jigsaw puzzle. Try and keep her occupied as this will take the mind off morbid subjects and thoughts. If the patient will do her own mending so much the better, as it will show that interest is being taken. If the doctor has suggested any form of treatment, the patient will turn to the nurse, and

will confide in her her nervousness regarding it. You can do such a lot to alleviate this by explaining as much as you possibly can about it, and assurance is always needed on the fact that she will not be left alone and that you will be there. To see a nurse she knows and can rely on is such a comfort to her.

Many patients worry very much when they know one nurse—the nurse who has done a lot got them—is going “off duty”; they are worried that the nurse taking over will not understand them or give them the same consideration. Make a point, when handing over, of reporting all the little things you do, and the patient’s little faddy ways; this will be much appreciated by the patient, and you will always have the knowledge that just the same will be done for her by any nurse taking over from you.

When the patient is allowed up, this is the time to see that she is occupied all the time, and to see that interest is taken in her personal appearance. So many lose this interest and it is up to you to see that it is not lost. In a large hospital there is always a hairdresser on the premises—arrange a visit there. See the doctor regarding a daily visit to the therapeutic department where various forms of sprays and douches are given; this will exhilarate the patient and help her very much.

Occupation and recreation are very necessary and, if the patient is pronounced physically fit by the doctor, should be encouraged as much as possible. In a large hospital the patient is handed over to the Occupational Therapist and Recreational Therapist in charge of either department, and from there various lessons in handicraft and sports are arranged; but in a Nursing Home this falls on the nursing staff and is more difficult, but a very necessary item of treatment.

The patient, by this time, will have been introduced to someone whom she can look upon as a companion, and if fond of walks, outings can be arranged—of course the nurse accompanying them—but for the patient to “get away” from the surroundings of the home or hospital even for a

short time during the day in the company of another patient who is suitable so that they can discuss everyday things, will do so much good; also a visit to the cinema to see a suitable film; looking at the shops. When they return their minds think in a different trend and interest will again be awakened.

Let the patient help make her own bed, arrange the flowers and any suitable jobs which she would like to do. It is very essential to keep the mind occupied, but not overworked. See that letters received are answered and so keep the interest to the fore, and the patient will feel herself getting back to normal once more. Many patients like to go to church, so do arrange for her to be taken by a nurse of her religion—many feel so uncomfortable when taken by one not of their religion.

There are social clubs arranged in many places,—take the patient along—she may be shy at first, but when she sees all the others joining in and the nurses, she will herself gradually be doing the same. These evenings which last about an hour are a great help to shy patients and they should be encouraged to join in.

During the course of the patient’s illness the relatives may be difficult, but try to treat them with the same quiet confident manner hoping that they will follow your example, and ask them to avoid giving the patient any bits of news which will distress or irritate in any way.

Although any treatment given to the patient by the doctor will speed up recovery, it is the little things and acts of kindness done by the nurse that helps to make life in hospital for the patient not something to look back on with dread, but something to feel for ever grateful for.

A depressed patient is often difficult over medicines, but never deceive them by putting anything in food. Explain what it is given for and why it is given.

The task which confronts the nurse is not an easy one, but by tact, constant kindness and perfect firmness the reward of seeing the patient discharged, recovered, should be won.

#### “COMMUNITY CARE” IN A BARNARDO VILLAGE

*“Slow or feeble-minded girls, were our joint responsibility. Mother, as well as the older more understanding people, felt them to be an added special care, and the encouragement and sense of personal responsibility for our ‘Potty’ was a marked feature of our lives. Woe betide any other ‘corrage’ who flurried or called out after our ‘potty’! She was ours and that was that.”*

*From “THE LIKES OF US”. By G. V. Holmes (a Barnardo child).*

## News and Notes

### "Mental Health"—the "Week's Good Cause"

A wireless appeal on behalf of the National Association for Mental Health was made by Miss Margery Fry, J.P., in the "Week's Good Cause" (Home Service) on Sunday, April 11th, at 8.25 p.m. Miss Fry spoke about the main aspects of the work of the Association, and particularly of the community service which it provides in helping those who have suffered from mental and nervous disorders to find the kind of life and work in which they can recover. She referred to the unhappiness, particularly of children, which could be avoided, given the right kind of help and understanding, and referred feelingly to her experiences in the children's courts where frequently it could be seen that a child's growing nature was being deformed by the mental condition of one of his parents.

Her eloquent appeal has resulted in the receipt of donations totalling to date £491 14s. 8d. Listeners from all over the British Isles responded and nearly 900 letters were received. Contributions were mostly in small sums, and there were several touching instances of old-age pensioners who, with true generosity, had saved up a few shillings. The Association is immensely encouraged by the amount of goodwill which the letters revealed, and the many expressions of keen interest in and support of its work. It would like to take this opportunity of thanking publicly all those who responded to the appeal and of recording its sincere gratitude to Miss Fry for her magnificent help.

### National Health Service Act. Exempted Hospitals

Under the National Health Service Act, provision has been made for the "disclaiming" by the Minister of certain Hospitals (including Mental Deficiency Institutions) with the effect of exempting them from transfer to the Ministry on the appointed day (July 5th).

A list of such Hospitals has now been issued (see *The Times*, 1st April, 1948) which includes the following Institutions and Homes for Mental Defectives :

Durran Hill House, Carlisle ; St. Joseph's, Sheffield ; St. Raphael's, Brentford ; St. Raphael's Colony, Potters Bar ; Field Heath House, Hillingdon ; St. Francis School, Buntingford ; St. Elizabeth's, Much Hadham ; Etloe House, Leyton ; Tubwell Farm and Dungates, Brighton Guardianship Society ; Totterdown Hall, Weston-super-Mare ; Lisieux Hall, Chorley ; Gilliebrand Hall, Chorley.

Only a small number of applications for exemption still await final decision.

The Ministry explains that there are, in the main, three grounds for allowing exemption : (1) That a hospital does not come within the definitions of the Act. (2) That it is not required by the Regional Hospital Board as part of the hospital or specialist services for the area. (3) That it is staffed, either wholly or in large part, by members of religious orders.

### Employment and Training Bill, 1948

This Bill repeals the Labour Exchanges Act of 1909 and the Unemployment Insurance Act, 1939, and brings up to date "the statutory provisions regarding the functions of the Minister of Labour and National Service and the facilities and services provided by him in relation to employment and training for employment".

The second part of the Bill concerns the Juvenile

Employment Service, providing for the setting up of a Central Juvenile Employment Executive to be staffed by officers of the Ministry of Labour and National Service, the Ministry of Education and the Home Office. In addition provision is made for the setting up of a National Juvenile Employment Council, consisting of 34 members appointed by the Minister of Labour, these to include persons nominated by various bodies such as the County Councils Association, the Association of Education Committees, the Association of Municipal Corporations, with representatives of teachers, employers, and workers, and of the Juvenile Employment Committees to be appointed by the Minister in such areas as he determines.

Local Education Authorities may be authorized to undertake any functions conferred on the Minister of Labour in connection with Juvenile Employment in accordance with schemes approved by him, such schemes to include provisions for the administration of unemployment benefit to persons under 18 years of age, and grants of assistance under the National Assistance Act to such persons. Further, the Minister may make regulations for requiring the proprietors of schools to furnish particulars as to health, ability, educational attainments and aptitudes of school leavers in order that vocational guidance may be adequately given.

This part of the Bill is based on the Report of the Committee on the Juvenile Employment Service issued in September, 1945, whose principles were accepted by the Government at that time.

### "Staff Aids" in a Mental Hospital

The Nottinghamshire County Mental Hospital, like every other institution of the kind, is seriously understaffed and as one way of dealing with the emergency, the Committee has instituted a new experiment.

With the co-operation of the Matron and Sisters, and the approval of the Board of Control, it has been decided to employ selected female patients, graded according to working ability, as part-time "staff aids". For their services small weekly payments will be made by way of reward and encouragement but the work is regarded chiefly as part of their general remedial treatment helping towards rehabilitation.

Patients capable of it are, of course, in all mental hospitals frequently given small household tasks to carry out, but the introduction of monetary reward and of a definite status and designation should act as an incentive and create a new interest.

### International Congress of Psychology

The Twelfth International Congress of Psychology (postponed from 1940) is to be held in Edinburgh from July 23rd to 29th, 1948. The Congress fee is £3 for Members and 30s. for Associates. The Members' fee is inclusive of the "Proceedings" containing abstracts of the papers which will be published.

Accommodation will be provided in Hostels for a considerable number, at an inclusive charge of £4 excluding midday lunch. It is hoped to find hotel accommodation for those desiring it, but early application is requested.

Enquiries should be sent to the General Secretary of the Congress, Godfrey Thomson, Moray House, Edinburgh 8.

**N.A.M.H. Courses for Transferred Relieving Officers**

In our last issue, we referred to the experimental course, organized by the National Association for Mental Health in co-operation with the Extra-Mural Department of the University of Manchester, for Relieving Officers and other Local Authority officers likely to be appointed Duly Authorized Officers in the new Mental Health Service. This course was attended by 39 men and one woman, and the report on it made by the Tutor (Miss M. Hamilton, one of the Association's Regional Representatives), shows that despite many difficulties inherent in the situation, it was an experiment that fully justified itself. The students were specially interested in the medical lectures on mental disorders and mental deficiency, and the visits of observation to Mental Hospitals, Mental Deficiency Institutions, Occupation Centres and Special Schools were observed to have a particularly vivifying effect. The Association is indebted to the University of Manchester for its co-operation in freeing lecturers to take part in the course and in providing premises.

A similar Two Months' Course began in London on April 6th. This is being attended by 38 students, the majority of whom are Relieving Officers (and in two or three cases, Mental Deficiency Officers) from the Home Counties although there are also students from as far afield as Newcastle and Plymouth.

A third Course is being held in Liverpool during May and June, intended primarily for Relieving Officers from the Lancashire area.

These two Courses also, are organized in co-operation with the Extra-Mural Departments of the Universities concerned and their syllabuses follow the lines of the Manchester Course including lectures on psychology and the social services, the mental health services and mental health social work, the work of a Duly Authorized Officer, mental disorders and mental deficiency, provision for the educationally subnormal child, child guidance, and epilepsy.

Ample opportunity is provided for discussion in small groups and visits of observation are arranged at intervals throughout the course.

**Incidence of Epilepsy in School Children**

An interesting article of this subject by Dr. Peter Henderson, a Medical Officer of the Ministry of Education, was published in *The Lancet* of March 20th, 1948.

The article reports an investigation, covering a school population of approximately 1,700,000 in the Northwest Metropolitan area, East Anglia and some of the Home Counties, carried out between October, 1946 and February, 1947, to ascertain the number of epileptic children who were in need of special school education and the total number of all children known to be epileptic.

The returns showed that out of a total of 776 epileptic children reported to the investigator, 519 (i.e. 0.3 per 1,000) were considered to be in need of special education and only 279 were actually receiving it. Of the remaining 240, 109 were not attending any type of school.

Despite the wide variations in the ascertainment rate in the regions sampled—from 0.2 to 2.5 per 1,000 of the school population—the investigation yielded clear evidence that if the average rate of 0.3 per 1,000 epileptics needing special education is applied to the whole country, the number of school places needed would be about 1,500 instead of the 660 (0.12 per 1,000) at present available.

(This estimate is, the report notes, borne out by the experience of the Manchester Education Committee

who maintain in their Special School at Salford Moss, 0.4 per 1,000 of their school population.)

Only a small proportion of the total number of children included in the Survey had been given a systematic intelligence test and the group so tested were evidently composed largely of those who had been refused admission to residential schools on account of low intelligence. The investigation could not therefore yield any conclusive results on the general subject of intelligence and epilepsy. But it is good to find the cause of the subnormal epileptic child is pleaded so earnestly by Dr. Henderson who writes ;

*To refuse a child admission to a special school, simply because his intelligence quotient is below 70, or even below 60, is doing that child a grave injustice. The very nature of epilepsy and the dulling effect of some forms of medication may combine to lessen a child's response to intelligence testing; to be fair to a child, these tests should be given on more than one occasion and should not be applied soon after a seizure.*

*. . . Even if after a reasonable trial at a school an epileptic pupil is found to be ineducable and in need of colony care, the experience gained at school will often make him a better colonist.*

*The handicap of epilepsy is often a barrier to employment that becomes well-nigh impassable to those who are also educationally subnormal and have not received education suitable to their limited abilities and aptitudes. A retarded epileptic who fails to secure or keep employment is a drag on society and a misery to himself and his associates. Employment is, too, the best anti-convulsant.*

*Thus, both on social and economic grounds, it is essential that every epileptic child, even if doubtfully educable, should be an opportunity for special education.*

Summing up his conclusions he lays emphasis on the following five factors to which attention must be given if the problem of epilepsy is to be effectively dealt with : (1) proper ascertainment by the school health service ; (2) greatly increased special educational facilities ; (3) regular medical treatment ; (4) effective after-care ; (5) a more enlightened public opinion.

**Social Psychotherapy**

*In reply to our request, Dr. Joshua Bierer, has kindly sent us the following information about the work of the Social Psychotherapy Centre (Institute of Social Psychiatry) of which he is the Head.*

This Institute includes two agencies :—

1. *The Therapeutic Social Club Centre.* This Section, which has now been opened exactly a year, is to centralize the activities of the Therapeutic Social Clubs : to advise all hospitals and out-patient departments with regard to the opening of the new Clubs, and, if possible, provide workers for them : initiate new Clubs and generally encourage and organize therapeutic work through the Clubs, combined later on with training and providing literature.

Patients, who are considered suitable for membership of a Social Club are referred to this Centre, where they are interviewed by a psychiatrist and recommended to attend a suitable Club (some of the existing Clubs are slightly different in character to meet the needs of the various types of patient for whom the Centre has to cater). The Clubs are entirely democratic, all types

## MENTAL HEALTH

mix well, and there is no financial obligation although a small weekly voluntary contribution, according to the person's means is asked for to meet the overhead expenses of the Clubs which are self-supporting.

*2. The Social Psychotherapy Centre*, the work of which is in its early stages, administers a combination of five forms of treatment, as follows :

1. Individual Psychotherapy.
2. Group Psychotherapy.
3. Social Club Therapy.
4. Occupational Therapy.
5. Art Therapy.

In the course of a patient's mental rehabilitation, and in his re-adaptation to normal life, it is often found that he will respond to all the above mentioned forms of treatment, given simultaneously, or to a combination of certain of them. The form of treatment suitable for each patient referred is decided by a Psychiatrist.

The patients are asked to pay a small amount towards their treatment to help to cover the expenses of the Centre. The amount is fixed according to their means.

The Institute of Social Psychiatry will also act as a Research Centre, in connection with these particular forms of treatment.

A training Scheme for Social Therapists is now under consideration and it is hoped will materialize in the near future. We are in the process of publishing a monograph on Social Club Therapy.

A plan for Membership of the Institute of Social Psychiatry is also being drawn up, whereby members would pay a fixed subscription and possibly receive two publications a year.

All enquiries should be addressed to : Dr. J. Bierer, Institute of Social Psychiatry, 7 Fellows Road, Hampstead, N.W.3.

### Dudley Voluntary Children's Care Society

This is an interesting piece of pioneer work based on co-operation between a Local Authority and voluntary enterprise and arising out of new opportunities consequent on the establishment of Statutory Children's Committees.

The chief aims of the Society may be summarized as follows :

- (1) To act as a link between the local authority and the general public in promoting the welfare of deprived children for whom the local authority has become responsible.
- (2) To assist the local authority in the finding of foster-homes and to help foster-parents to understand the needs of the children under their care.
- (3) To help the local authority in providing a home background for children in Residential Homes, and in the provision of after-care and suitable lodgings for children placed in employment or under training.

A representative committee, under the chairmanship of Councillor Dr. F. G. Lewis (Chairman of the Children's Committee) has been appointed and applications for membership of the Society are being invited.

Further particulars may be obtained from the Hon. Secretary, Mr. C. M. Walker, Director of Social Welfare (at present acting as Hon. Secretary), 7 St. James's Road, Dudley, Worcestershire.

## MENTAL HEALTH

### Council for Music in Hospitals

In November, 1947, there was formed, with the sanction of the Board of Control and the active support of a group of medical superintendents of Mental Hospitals, a Council with the following objects :

"To organize and provide regular series of concerts of music of a high quality ; to assist in organizing lectures, meetings of gramophone clubs, etc., in hospitals on some planned scheme; to assist hospitals in experimental work on the value of Musical Therapy for individuals or for groups ; to encourage patients on leaving hospital to continue their interest in music and to keep them in touch with musical circles near their homes."

Already a number of concerts have been given by eminent artists, prefaced by simple explanatory talks which are greatly appreciated. Programmes are, moreover, sent to the Hospitals in advance to enable preliminary lectures and gramophone recitals to be given to the patients as a further help in understanding the music which they are to hear.

The Chairman of the Council is Mr. Frank Howes (Music Critic of *The Times*), and the Hon. Treasurer, Mr. Stanley Rubenstein, who is well known to London hospitals through the gramophone recitals which he has been giving them. The members of the Council consist of ten Medical Superintendents, and Captain Croft-Cohen of the Board of Control has been appointed as an "observer".

The formation of a Sub-Committee for research work on the therapeutic value of music assisted by reports received from Medical Superintendents, nursing staff and artists taking part in the scheme, is one of the Council's immediate projects.

Further particulars will gladly be supplied by the Secretary, Miss Sheila McCreery, 4 Campden Hill Square, London, W.8.

### Answers in Parliament

#### *Maladjusted Children*

In answer to a question on February 19th, the Minister of Education stated that there was accommodation at present in special schools and boarding homes, for 527 maladjusted children. The number of children ascertained as maladjusted was, on January 1st, 1947, 5,795 (boys, 3,896 ; girls, 1,899), but it was considered that the great majority of these could be appropriately treated in Child Guidance Clinics.

There are eight proposals for special schools for this category of handicapped children under consideration at the present time.

#### *Mental Deficiency Institutions*

The Minister of Health stated on November 6th, 1947, that 160 beds would be available in the near future in premises recently acquired by local authorities. Further accommodation would also be available in three colonies released by Service departments.

No comprehensive figures as to the number of defectives awaiting institutional vacancies have been issued since the publication of the Board of Control's Report, for 1946, in which it was stated that there were on January 1st, 1947, a total of 3,890 waiting cases.

**International Congresses of Medical Sciences**

In April, Dr. Soddy represented the International Congress on Mental Health at the second meeting held at UNESCO House, Paris, of the Organizing Committee of the Permanent Bureau for Co-ordination of International Congresses of Medical Sciences. The Bureau is jointly sponsored by UNESCO and the World Health Organization, and representatives were also present from the United Nations Social and Economic Council and the International Refugee Organization. Other organizations represented on the Committee are those concerned with venereal diseases, paediatrics, surgery, cancer, radiology, rheumatism and tuberculosis.

The Committee unanimously recommended the establishment of a Permanent Bureau with the following functions:

**I. Information and Assistance.**

- (1) To collect information on all national or international organizations of a medical or paramedical nature, and on the congresses which they organize.
- (2) To give all possible material assistance and in particular, specialized conference services (staff, technical material) and travelling facilities for congress members (visas, etc.).
- (3) To study methods of facilitating the transfer of funds needed by congress members.
- (4) To study and disseminate information on the technique of congresses.

**II. Co-ordination.**

- (1) To take active steps to suggest to international medical bodies, appropriate dates and places for the holding of their congresses.
- (2) To make a special effort to group disciplines together.
- (3) To give financial assistance to the scientific work of congresses and make grants to congress members who particularly merit them.
- (4) To give grants to enable representatives of different disciplines to take part in congresses.

**III. Diffusion of Information.**

- (1) To take steps to circulate information received in accordance with Paragraph I (1).
- (2) To study the whole problem of the dissemination of medical knowledge, including the circulation of documents resulting from the work of the congresses.

The bodies eligible to participate will be international organizations of a medical character.

Dr. Soddy reports that he was struck with the degree of mutual confidence attained at this meeting and the unanimity displayed by the members of the Committee in their desire to establish the Bureau, creating an atmosphere too seldom achieved at international gatherings.

**A South African Psychiatric Hospital**

The Vice-Chairman of the National Association for Mental Health, Lady Norman, paid a visit to South Africa during the winter and saw much municipal and

voluntary social work for Europeans and non-Europeans in the Union.

Amongst the many hospitals, schools and institutions she visited on behalf of the National Council of Social Service, she mentions the Tara Psychiatric Hospital, a few miles outside Johannesburg. She writes :

" Tara Hospital in Johannesburg is a legacy of the war, but is now devoted entirely to civilian patients of all ages, and run by the Provincial Authorities.

Dr. Alice Cox, M.D., Glasgow, took me all round, as the Medical Superintendent was away and the Matron, Miss Warwick, was in England taking a Course at the Maudsley Hospital.

Some of the work was exceedingly interesting and in some ways rather novel. There was a dolls' house for children where the weekly clinic is held; the furniture is all small, and it is fitted out with pots and pans and china, a little kitchenette, a bedroom and everything to delight a child. The children's clinic is held in this dolls' house once a week, the children coming out by private bus, from the town.

I saw some of the excellent work being done by the patients, who are of course all voluntary, and the millinery was of the highest standard, as well as the leather work done by men and women. From the point of view of occupational therapy, I have never seen anything to beat it.

I also saw a gymnasium class, both for men and women, taken separately; it was very remarkable, for it was taken by a first-class teacher who, besides being very good at her job, was good to look upon, had a beautiful figure and exquisite face. Patients seemed to enjoy the work, which was done to music, the piano being played by a gifted pianist.

The final exercise was one of complete relaxation, lying on the floor and taken to very soft music and the gentle beating of native drums. When it was over, it was quite a long time before the patients felt inclined to get up, and I myself felt very rested and at peace with the world."

Unfortunately, Lady Norman reports that there is a possibility of the Tara Hospital being closed down, owing to the enormous expense per patient. In view of the splendid service it is giving to the patients (some 150 of them), in addition to its out-patient facilities for young children, it is devoutly hoped that such a disastrous contingency may be averted.

**Children and the Cinema**

The Home Secretary, the Secretary of State for Scotland and the Minister of Education have recently appointed a Committee to consider and report upon :

- (a) *the effects of attendance at the cinema on children under the age of 16, with special reference to attendance at children's cinema clubs;*
- (b) *whether, in the light of these effects, any modification is desirable in the existing system of film classification, the existing position with regard to the admission of children to cinemas, or in the organization, conduct and management of children's cinema clubs.*

The omission of a child psychiatrist from the Committee appointed, whose membership is representative of so many other interests, calls for comment. The work upon which the Committee is engaged is the subject of study and also of special interest to mental health experts whose views and knowledge would undoubtedly be of value in an enquiry of this kind.

## Book Reviews

**Mental Health.** By J. H. Ewen, F.R.C.P.E., D.P.M.  
Edward Arnold & Co. London. 12s. 6d.

This sets out to be "a practical guide to the disorders of the mind" and it provides a concise yet comprehensive account of psychological medicine, which will be helpful to the general practitioner, the student and the would-be specialist who seek an introduction to mental hospital practice. The resident doctor here will find the chapters on his responsibilities and on the survey of the legal aspects most useful as a reference; though the note on the recommendation of the Atkin Report (p. 250), that irresistible impulse should be accepted as a plea of non-responsibility, might be followed by the comment that this recommendation has not yet been carried out.

The account of the psychoses is full and clear, though it may be questioned if the case histories add much to the student's understanding—Dr. Ewen has perhaps felt he can have no room for such lengthy reports as the classic case histories of Henderson and Gillespie—but his resulting brevity leaves notes which lack colour and life. The chapter on specialized methods of treatment (largely physical) is good, and useful as a guide and as a reference.

In his description of the psycho-neurosis which, incidentally, occupies less than a tenth of the book, Dr. Ewen is on less sure ground; and his outline of treatment makes it all sound very easy. The reader might welcome a little more detail about how to "create new interests" for the neurasthenic (p. 85) and how to "insist on his facing the reality of life's circumstances". Moreover, there is only a passing reference to the influence the whole attitude of the doctor may have on the patient. Psychosomatic disorders are very sketchily handled, and indeed the index shows only one reference in the introduction. The book does, therefore, not contribute much for the practitioner dealing with the neurotic.

The form of the book could be improved by a fuller index and the correction of a few misprints, though one of the latter, "over weaning" arrogance (p. 4) is delightful.

R.F.T.

**Clinical Studies on Psychopathology: a contribution to the Aetiology of Neurotic Illness.** By H. V. Dicks, M.A., M.D. 2nd Edition. Edward Arnold. 15s.

This is the second edition of a book which has earned for itself by its honesty and vividness a special place in English literature on psychopathology. The new issue contains some minor alterations and some additions, but in the main the book is unchanged and it remains an important coherent statement of views derived from practical experience in the elucidation of psycho-neurotic problems. It matches and contrasts theories with real happenings within the author's experience and is richly illustrated with case notes derived from behaviour and statements in analysis (the method of analysis in so far as it deviates from orthodox psychoanalysis is described). The case notes are used as a testing ground and for illustrations of theory, and from them the author draws his discussion and conclusions on points of psychopathology. The reader, in whom some familiarity

with the major concepts and language of psychopathology is assumed, is asked to accept no *ex cathedra* views, but is presented with the author's methods, his information sources and his conclusions, argued with learning, moderation, integrity and wisdom. It is of course a highly personal book, the fruit of the author's work, reading and thought in this field, and is intended not as a textbook but only as a personal contribution to discussion of psychopathology.

Professor Dicks declares himself as an eclecticist and is prepared to reject the views of any school unless they withstand the test of practice and reflective evaluation. On the other hand he finds much of use in various schools and his own view-point is a synthesis of derived and original concepts selected partly for practical and partly for theoretical reasons. His conclusions are mainly in support of Freudian theories, but with Hadfield he is unable to accept the Oedipus situation as the common source of early anxiety, while his view of sadism as a secondary fusion of sexual with aggressive impulses is the result of his own experience with patients. The case material was interpreted in the light of instinct psychopathology, but the author does not exclude the pathology of object relationships as a future basis for behaviour interpretation. This edition reviews some of his earlier conclusions in the light of the literature of the last eight years and includes tribute to the writings of Brierley, Fairbairn, Horney and Klein.

In a new last chapter a vigorous plea is made for the recognition of the reality of emotion by those who would deny its existence except as an epiphenomenon, and he argues cogently against the nihilism of mechanistic views of human behaviour. This thoughtful book, rich in independent thinking and scientific humility, is written with economy and lucidity. It is a pleasure to read and can be firmly recommended to all who are interested in attempts at the objective study of psychodynamics.

T.F.M.

**Personal Mental Hygiene.** By T. W. Moore, O.S.B., Ph.D., M.D. William Heinemann. 21s. net.

This book, as Professor Moore points out in his introduction, is intended for the individual. It is an attempt to remedy what the author feels is a defect in modern psychiatry—the neglect of ideals and principles and the adjustment of mechanisms "on the emotional plane without rising to anything of an intellectual or spiritual character". Although we may wonder if Professor Moore has not been too sweeping in his generalized condemnation of psychiatrists on these grounds, there is no doubt the sincerity of his attempted remedy. The book sets out to describe emotions and attitudes and their origins: and lays down certain rules whereby unwholesome attitudes may be prevented from becoming fixed. Various case studies of the author's patients are given, together with illustration episodes of the lives of certain poets, whose work demonstrated their emotional difficulties.

The appeal of this book is likely to be to a rather limited audience, for it is somewhat too technical and presupposes too much knowledge to be readily helpful to the individual seeking advice on his own problems; while, on the other hand, its form is too discursive

and vague for the more experienced. Moreover, in view of his expressed aims, many readers may be disappointed that the author does not in fact provide more spiritual or intellectual help, though he certainly succeeds in his intention of indicating the need.

R.F.T.

**How to Interpret Social Welfare.** By Helen Cody Baker and Mary Swain. Routzahn: Russell Sage Foundation. \$2.50.

This book sets out to tell Social Agencies how to "sell" their Welfare by the Spoken Word, the Written Word, in Pictures and finally by Planning. It opens with a diagram: the Agency is the sun round which revolve in dazzling fervour Volunteers, Clients, Co-operators, etc., and lastly, in the outermost circle, the General Public. The authors describe the work as a "basic study course in public relations". Some of the lessons strike one as rather elementary; for example before a board meeting: "by practising the conversational skills discussed in Chapter I you can make your board members feel that they are welcome and needed". About panic before making a speech we are told that "beforehand nervousness charges your batteries", and we are instructed in letter writing that "Plus values in goodwill may be gained by improving the quality of letters". In connection with the preparation of Social Agency Bulletins the would-be editor is counselled to remember that "the most effective bulletins of all are those that know exactly what they intend to accomplish. . . . Don't take reader interest for granted". This is How to Win Friends and Influence People on a grand scale.

The illustrations do not make more serious demands on the student and there are hints on "humanizing statistics" that develop the technique of the pictograph—rows of little men, one mutilated, showing what is meant, relatively speaking, by "23 per cent.". It is questionable whether this method achieves its aim. The telling use of photographs, however, is well shown by six that illustrate the use of artificial limbs. Some diagrams, not to mention the comic strips, are rather puerile: for instance a tree of black foliage labelled Services and white roots labelled Taxes. The value of such methods, in this country, is doubtful. Perhaps the idiom is indigenous but the reviewer's seven-year-old enjoyed the pictures. The publishers tell us that one of the authors "has been writing since the age of sixteen". One cannot help feeling she has earned a rest.

J.H.W.

**Modern Psychiatry in Practice.** 2nd Edition. By W. Lindesay Neustatter, M.D., M.R.C.P. J. & A. Churchill, Ltd., London. 12s. 6d.

This book, which is intended mainly for the medical student and the non-specialist practitioner, attempts, in 269 pages, to cover the whole field of psychiatry; it includes chapters on psychopathology, psychoses and psychoneuroses, mental deficiency, treatment, the preventive and legal aspects and even some of the "specialties" of psychiatry. It is therefore greatly to the author's credit that the book is as readable, comprehensive and valuable as it is. At the same time, it is, of necessity, dogmatic and sometimes tantalizing in the brevity with which it deals with important and interesting aspects of the problem. For the most part the balance between importance and space of text is well held, but some pruning of details, unnecessary to the type of reader for whom it is meant, would improve

the book and make more room available for essential features elsewhere. It will seem to some also that the author's highly personal, and sometimes even racy, style could have been made more succinct with benefit to both the amount of subject matter covered and the "dignity" of the book. It is only fair to say that Dr. Neustatter emphasizes his desire to get away from "the immense amount of dreadful jargon", which permeates so much psychiatric literature; at the same time few textbooks, even of the simplest type, are improved by the use of such numerous exclamation marks.

In a book of this type, it is unfortunate that a number of errors have been allowed to creep in. It is doubtful, for example, if many psychiatrists, especially those with Army experience, would agree that enuresis "practically never persists after puberty".

Even with these faults, this is a valuable contribution to the more elementary textbooks on psychiatry. It gives an excellent, and usually readable, description of many aspects of psychiatry, and it should do much to stimulate interest and further reading by the student. It will, too, give the practitioner a fair and sensible approach to a subject which so often puzzles, and sometimes infuriates, him by its apparent complexity and contradictions.

In this second edition of the book, new chapters have been added on psychopathy, neuropsychiatry and physical therapy, whilst many of the other chapters have been enlarged or re drafted.

T.A.R.

**The Selected Writings of Benjamin Rush.** Dagobert D. Runes (Ed.). New York Philosophical Library. 1947. \$5.

Benjamin Rush was considered by many the greatest physician of his country (America) and time (late 18th century); he was also a great patriot and champion of freedom and common sense in man's affairs. He was a pioneer in the use of occupational therapy; he saw the psychosomatic aspects of many diseases, was something of a psychiatrist—even in his day—and was amongst the very first to encourage analytical conversation in his patients. These facts alone should interest the readers of this magazine in his writings.

But the book is over 400 pages, and much that it contains is *passé* or actually wrong: thus for all his insistence on research and experimental method, for all his novel (and often advanced) ideas, and open mind, he still implicitly and explicitly assumed bleeding to be a standard treatment.

Nevertheless, many selections are well worth reading for pleasure alone (the quaint style of this period always charms, and its humour amuses); and some of his pieces are informative. "Medicine Among the Indians of North America", for instance, is a careful and observant sociological and anthropological study—so also, to a lesser degree, is his diary of a visit to France, "On Manners".

His advice in all things recommends the golden rule; in drink, dress and manner he would even err on the side of conservatism. He was not reluctant to advise on slavery, newspaper publishing, education, government, religion, morals, ethics, capital punishment, and agriculture. Nearly always he spoke with wisdom and care.

What he said about the physician's bedside manner, and what is now called "the total situation" (p. 313), may well be read with profit. He anticipated by decades the "equilibrium" hypothesis (pp. 133, 136 and 167-8), gave a description of the hypochondriac and obsessional (p. 188), and offered a classification of "manias" and

## MENTAL HEALTH

"phobias" (pp. 212-26). The human mind was his special interest, he studied and admired its complexity; and always he gave it first place. He well deserves a place amongst the fathers of practical psychotherapy.

J.F.S.

**Education and Health.** By R. Gamlin, M.A., M.R.C.S., L.R.C.P., D.P.H., Chief Assistant School Medical Officer, Liverpool. Jas. Nisbet. 12s. 6d.

Dr. Gamlin has made a most ambitious attempt to provide a survey of many aspects of health, mental and physical for the benefit of teachers, parents and others concerned. His book is readable, well illustrated and attractively set out; the matter is succinct and comprehensive, and the reader will gain a clear impression of many factors which influence health, and be led to understand the methods of controlling these factors. It will thus be a valuable book for many, though it would be better if it furnished a wider and better arranged bibliography of deeper reading to satisfy the appetite of the eager reader stimulated by this *hors d'oeuvre*.

The book is, however, a little disappointing in its discussion of mental health. Dr. Gamlin devotes his first four chapters to the workings of the mind, and his next three to maladjusted children, juvenile delinquency, and backwardness, so that the reader should be left in no doubt of the prime importance of the psychological angle—with which, of course, we cordially agree. But with all this space given to it, the subject is dealt with on too superficial a level; and could have been written more profoundly without losing any of its appeal or clarity. The first chapter for instance, pointedly entitled *homo sapiens* deals with suggestion, superstition and the credulity of Mesmer, Joanna Southcote and others, but makes little attempt even to describe the factors underlying group and individual suggestibility, nor is further reading indicated.

Nevertheless, the book is one to be warmly recommended to anyone wishing to acquire a comprehensive introduction to the whole relation of education and health, and if it stimulates further reading, it will have served a most useful purpose.

R.F.T.

**Mental and Scholastic Tests.** Revised Edition. By Cyril Burt. Staples. 35s.

This volume, one of vital importance to all interested in the problems and implications of mental testing, makes a timely reappearance in a second and enlarged edition. Here we have a detailed description and analysis of the investigations carried out by the author during his years spent as Psychologist to the London County Council. The appointment of Dr. Burt to that post in 1913 marked the beginning of a new era in the assessment by scientific methods of children's intelligence and educational attainments. His own words, give in the preface to the volume, show what were the duties expected of him. "To assist teachers by developing means both for the examination or ascertainment, and for the education or training, of the various types of children needing special provision or attention." This covered the study of subnormal pupils of all types (backward, dull, mentally defective, delinquent and nervous) as well as of the supernormal. But here, as in other spheres, the study of the normal and deviations from the normal complement each other and form part of the same investigation. To Dr. Burt falls the distinction of having been the pioneer in introducing in this country, the now generally accepted methods for

the assessment of intelligence and educational attainments of children of all types.

The volume is divided into three main sections or memoranda—the first dealing with Burt's revision for English children of the original Binet-Simon Scale of Intelligence Testing; the second with the theoretical validity of the results, and the third with Burt's own tests of educational achievement.

In the new edition of this book, the main bulk of the work is unchanged, but several additions or appendices of great importance and interest to present day practice have been inserted. In the first appendix the author discusses the nature of intelligence, with special reference to the distinctions between various types of theories. In the second appendix he gives a detailed factor analysis of the Binet-Scale. In the remaining ones he deals with such valuable topics as the accuracy of his own supplementary tests; the contribution of schooling to the scores on the Binet Test; the concept of mental age and some of the difficulties inherent in it; and the vexed and very pertinent problem for present day psychologists and educationists of special abilities and the extent to which such abilities can be assessed in mental tests, and at what specific ages this assessment can be most accurately carried out.

It is a pity that Professor Burt has not yet been able to complete his revision of the Terman-Merrill Scale, and to include his results in the present volume. Let us hope that by the time the next edition appears, this will have been completed, for it will form a very valuable addition to what is still the most outstanding treatment of the whole subject of mental testing.

This is a book which should be in the hands of all teachers, school medical officers, education officers, psychologists and those concerned in the present day problem of "educating the child according to his age, ability and aptitude".

G.H.K.

**London Children in War-Time Oxford. A Survey of Social and Educational Results of Evacuation.** By a Barnett House Study Group. Geoffrey Cumberlege, Oxford University Press.

Some of the facts about evacuation were gathered hastily under the pressure of events or with an eye to urgent practical decisions. This study of London children in Oxford city and county undertaken during the years 1941-3 is a more leisureed consideration of what can be learned from this migration of city-dwellers to the countryside. The authors, working under the chairmanship of Professor W. G. S. Adams, were primarily interested in the meaning of evacuation from the standpoint of the child's educational development, considered in its widest sense.

In spite of considerable differences in material and method, some of the main conclusions are strikingly similar to those found in the Cambridge Evacuation Survey.\* The 319 children all aged over eleven represented a much wider variety of London areas than the larger number coming only from two London Boroughs which was studied in the Cambridge inquiry, and some of the children studied in Oxford were with their mothers, or were living in a camp school. The smaller number is to some extent compensated for by useful comparative groups of local Oxford children and of London children who remained at home.

\* "The Cambridge Evacuation Survey." Edited by Susan Isaacs. Methuen. London. 1941.

A combination of quantitative measurement, sometimes used too uncritically, and of well chosen illustration, the study throws light, with a refreshing lack of scientific pretentiousness, upon a number of questions of importance to family life, social relationships and education.

Both the Oxford and Cambridge study provide remarkable evidence of the adaptability of children. A large proportion of boys and girls in both areas, already of course "selected" by influences difficult to weigh, were able to make reasonably good adjustments, at any rate on the surface. That this was not done without cost was shown by the clinical study of some of the children in Cambridge; more may be learned of this in the future. There is further confirmation of the relation between the child's resilience and his confidence in the enduring love of his parents, in the higher proportion of successful children whose parents maintained close contact with them by visits and letters.

A particularly valuable chapter on delinquency shows that there was in this area, at any rate, no reason whatever for blaming upon the newcomers the steep rise in delinquency. It was found, moreover, that some of the London children coming from homes calculated to produce delinquents settled satisfactorily in foster-homes where they were offered unusual understanding. This suggests the immense value of research which is based upon the study of satisfactory social behaviour under apparently adverse circumstances.

In both these surveys there is encouragement for those who believe that there are in the community many homes in which the children of other people may be welcomed and well cared for.

The devotion of children to the familiar is apparent all through the study. Few of these children would choose to live elsewhere than in London, though many write with real delight of the countryside. Nor are they lacking in social observation and comparison. "Oxford is divided into two parts", wrote the fourteen year old son of a policeman, "master and serfs, the college people and gentry being first, and the working class people working for them, whereas in London everybody is the same as everyone else."

There is evidence that teachers and children alike, sharing the creation of their own education, discovered new interests and resources. This experience is used to support the view that every child would gain from a country department of his school in which he could spend in a residential community two or three terms of his school life.

This small book is excellent value and a good illustration of what may be accomplished by a team of field workers under able direction.

S.C.B.

**The Snake Pit.** By Mary Jane Ward. Cassell & Co. 8s. 6d.

Any attempt to depict a medical illness in a biographical form is difficult enough to a trained observer if it is to remain a true likeness; to attempt such from the sufferer's point of view of a fully fledged psychosis and at the same time maintain that semblance of coherence which is necessary if it is to remain intelligible, is well nigh impossible. It is not surprising, therefore, on commencing this book to find oneself at a loss—our orientation is disturbed, and until the mind of the reader is attuned, it gropes about in a motley of impressions as confused as is indeed the sufferer. The initial resistance of trying to make sense out of confusion gradually yields to a passive absorption—at times misty,

at times clear—but with increasing fascination, so that we follow closely the strivings of this tormented mind on its vacillating and irregular path slowly upwards towards recovery,—especially so, as our understanding increases.

It is a good book and well written. It is good from two points of view. First what we learn about the patient and mental illness as a whole, and secondly about Mental Hospitals. We realize that this patient is a sick person—ill, and yet perhaps to many, rather different to what we would visualize an insane person to be. We are able to feel acutely for her without that sense of repugnance which is so easy to adopt on a superficial contact. In fact in some passages, one is almost tempted to believe at first sight she is the subject of victimization, until we realize her lack of insight, and that not only does she view things differently, but to her they are different. Despite her loss of contact and strangeness, she yet realizes early that she is in a Mental Hospital and how impossible it is for her to convey to others how she actually feels—that even when she may appear well, she knows that things are not quite what they should be and that finally—even when better—the dreadful problem of readjusting to an outside existence is not the simple process that is expected.

As to the hospital (even though American), I think I can say it is very representative in the main, or at least from the patient's point of view, of those here—that human relations being what they are, it is impossible to expect a large community under enforced conditions, to live as one big happy family. In fact, many Mental Hospital patients are not happy; they do miss their liberty and other amenities and few are so insensible to their surroundings not to long for home. Equally too, it must be realized that being ill they are in as much pain as their counterpart, the physically sick; perhaps even more so, as a mental anxiety, fear or whatever it may be, is of long duration and inescapable. The days of the manacling of patients may be over, but it is easy to see that even though no patient is ever badly treated, the problem is far from solved and will remain so until further treatments can promise an even higher degree of cure, especially for those who, at the moment, become long-term residents.

I have hardly been able to touch the fringe of the many problems raised in this book—the more discerning will find much food for thought, and even the psychiatrist will find the study enlightening.

R.B.M.

**Just Murder.** By Edward Robinson. Lincolns-Prager, London. 1947. Pp. 271. Price 12s. 6d.

This book has an excellent introduction by Professor Harold Laski, in which he explains that the author's aim is to advocate the reform of the law respecting those accused of murder whose plea is insanity at the time of the alleged offence. The duty of the judge in his instruction of the jury in such cases is based upon the McNaughten Rules of 1843. McNaughten shot and killed Mr. Drummond, Sir Robert Peel's secretary, in the belief that he had killed Sir Robert himself, and under the delusion that he was being persecuted by the Tories. He was found "not guilty" on the ground of insanity.

Much controversy was raised by this case, and, after a debate in the House of Lords, five questions were put to the Judges, and these resulted in the formulation of the McNaughten Rules, which may be stated thus: To establish a defence on the ground of insanity it must be clearly proved that at the time of the act the party

accused was labouring under such a defect of reason from disease of the mind as not to know the nature or quality of the act he was doing, or, that he did know it but did not know that it was wrong.

If the accused is undoubtedly insane and unfit to plead, and the jury agree, the judge may order his detention in Broadmoor. If it is decided that he is fit to plead, and the defence of insanity is persisted in and accepted by the jury, the verdict will be "guilty but insane", and that also means Broadmoor. When the accused is found to be insane on arraignment, he is not found guilty of an offence and his mental condition at the time of the alleged offence is not inquired into. If found "guilty but insane" he is found guilty of the charge and his mental condition at the time is inquired into. Thus he may be of sound mind at the time of the trial and yet be sentenced to detention as a criminal lunatic.

These complicated possibilities make a very serious set of problems for judge and jury.

It is easy for Mr. Robinson to show by means of examples of trials which occurred between 1919 and 1939, that the result of all these complications is most unsatisfactory from a psychological viewpoint. The cases are excellently chosen, but it is a great pity that the author has not classified them so that the reader should be able to grasp clearly the kind of confusion or injustice represented by each case, and the different forms of injustice which seem to him to run through them all. It is not sufficient that the cases should be left to convince the reader by themselves, and a careful summing-up by the author would have been a great help. Dr. Charles Berg's interesting "last word" is very valuable and could not be dispensed with.

This book, though the author does not consciously intend it as such, is perhaps one of the best kinds of argument that could be brought forward for the abolition of the death penalty altogether. The very fact that a man has committed murder is the strongest piece of evidence of his gross mental derangement at the time.

If there were any evidence that punishment helped people who had committed murder, so that they were less inclined to do it again, then there would be a possible case favouring punishment, but the murderer's death does not help anybody, least of all the murdered man, and all attempts to show that the death penalty has a deterrent effect on others are unavailing. Murder has never become more common where the death penalty has been abolished. The McNaughten Rules are a relic of psychological ideas probably out of date already in 1843, and the death penalty is a relic of the cruel forms of retributive justice dating from the Middle Ages and earlier times.

R.W.P.

**Psychotherapy—Its Uses and Limitations.** By D. R. Allison, M.D., M.R.C.P., and R. G. Gordon, M.D., D.Sc., F.R.C.P. Geoffrey Cumberlege, Oxford University Press. 8s. 6d.

As the authors modestly say in their preface this small book sets out to be a guide to the student and practitioner, as to the sort of case where they may expect help from the specialist in psychotherapy; and how the physician and the family doctor may often help the patient to conquer his disease. In this, deliberately limited, aim, it amply succeeds and its 156 pages are full of sound advice, well set out, easy to read, and illustrated now and again with case histories. The authors have wisely resisted the temptation to go into too much detail,

which might well have made this book less valuable, by taking away from its simplicity and ease of reference. As it stands, it will be an introduction to the scope of psychotherapy for the student, and the practitioner faced with the day-to-day problems of individuals will find even more help and practical advice; and though it is not written primarily for them, the social worker and nurse, and others interested in the human problems of their fellows will benefit from its lucidity.

Indeed its common sense approach and reasoned tone, and the fact that it emphasizes psychotherapists' agreements rather than disagreements, will go far to achieve the authors' more ambitious aim—of making an end of suspicions and rivalries and letting all branches of medicine combine as a team "which can deal with both psyche and soma, with individual and environment, all of which indeed are indivisible".

R.F.T.

**A Text-book of Mental Deficiency.** Seventh Edition. By A. F. Tredgold. Baillière, Tindall & Cox. 1947.

This is very much a personal effort and a personal statement but, 40 years after the first edition, the author is entitled to write in that way and to expect his views to have attention. Some of the views may, perhaps, invite disagreement, but that is a healthy condition where knowledge is not yet complete or assured. The important thing is to have a full statement of the facts that are known, a full and vivid description of the various conditions with which we are concerned and a discussion of the theories which may explain them.

For these reasons this is still the best book on Amentia and a safe source to which anyone can refer for information. All the facts are here and, considering the present difficulties in the production of books, the facts are remarkably up to date. The latest syndromes are described and the references are given fully and are most useful.

The illustrations include many old friends but also a number of new ones and the whole book is up to the old standard in quality. This is the publishers' contribution to a new edition which is also a new success.

N.H.M.B.

**Psychiatric Research.** Harvard University Monograph in Medicine and Public Health. Geoffrey Cumberlege, Oxford University Press. 11s. 6d.

The occasion for publishing this book is perhaps as interesting as the book itself; it was the opening of a new laboratory for biochemical research on psychiatric problems at the McLean Hospital, the psychiatric department of the General Hospital at Boston (Mass.). To this came a number of eminent visitors whose invited speeches form this volume. They included professors of physiology, neurology and psychiatry, and their papers cover problems ranging from the general needs of research to biochemical studies of cerebral function in great detail.

The book is thus primarily for the doctor or scientific research worker, and will be somewhat too abstruse for other readers; who may nevertheless be interested in the breadth of vision and detail of research framed in this ambitious undertaking.

R.F.T.

**Oxford Essays on Psychology.** By William Brown, F.R.C.P. Heinemann Medical Books. 10s. 6d.

This book is composed of seven lectures given to students at Oxford in recent years. It does not claim to treat exhaustively any of the aspects of psychology with which it deals, but it is very far from elementary. It will be of interest to the intelligent general reader, especially if he has already some acquaintance with psychological theories.

The first chapter deals with the general principles of psychology and the instinctive basis of mental activity.

The classical orthodox view of instinct is taken in this, and succeeding sections and although the author acknowledges a debt to Freudian psychology and accepts much of the teaching of the Freudian school the impression is given that this must fit into the classical structure rather than that the latter should be altered to accommodate the dynamic new psychology.

In the next chapter under the heading of "The Gregarious Instinct" the author discusses the nature of "transference", and goes on to demonstrate the effect of the transference situation in the relationship of group and leader, with particular reference to the mass psychology of Nazi Germany. Here also we have the consideration of the formation of the super-ego, of compulsive elements within it and of the projection of undesirable qualities upon the enemies of Nazi Germany.

The following chapter deals with the inferiority complex and reactions against it and with the paranoid

tendency and its frequency. These factors are also applied to the German situation, and their influence on the German national character is shown.

It is felt that this examination of the German mass mind, which will probably be found the most interesting part of the book does not sufficiently emphasize the enormous capacity of the German for subservience to leaders. This, based on early repression of the more tender emotions associated with the mother-child relationship, and acceptance of a harsh father identification, would seem to be a very potent factor in male German psychology.

There follow two chapters on the socio-political aspects of psychology, and finally we have a brief survey of medical psychology and the type of disorder that is the province of the psychiatrist. Methods of treatment are briefly mentioned with emphasis on the value of relaxation. Not every one will agree with the wholesale condemnation of alcohol and tobacco that the author makes in this section.

The use of these substances in moderation is of value socially, and frequently of greater, more personal psychological value. It is surely better in the constant struggle to adapt to the demands of living that one should use alcohol and tobacco in moderation, than that one should be obliged to adopt some of the more crippling devices used as a defence or protest against life's demands.

R.F.R.

## Film Reviews

**No Orchids for Miss Blandish.** (Featuring Linden Travers, Jack La Rue, Hugh McDermott.)

With London at the moment divided between those queuing with eager anticipation at the Plaza and those clamouring with strident indignation for the removal of this film, it is difficult to make any moderate comments without being accused by the anticipators or the indignant of belonging to the opposite group.

For a beginning I can side wholeheartedly with the indignant by regretting that this film was ever made. When the quality of British films is rising and the demand for them abroad is growing, what folly to jeopardize that reputation with such a bad film. With money short and the expense of film making nearly prohibitive, what wicked waste to squander it on such a subject. There may be too a sense of wonder in those who have seen the spate of psychological films in the last year that a story in which motives and feelings are of importance could have been produced in such a crude and unsatisfactory form today. One has become a little tired of the film psychiatrist recently, but after a surfeit of revolvers, one began to long for his arrival.

Having unreservedly regretted that such a British film should ever have been made, it may perhaps be suggested that the outcry against it is unwise and possibly even a little exaggerated. If the film was made in the belief that safe box office returns would accrue from the repressed Englishman's hankering to be shocked, then the outraged cries of the indignant are so much grist to the mill. I must admit that I have seen other films (mostly "B" ones, certainly) that contained the same sort of contents, but they died a natural death—the very fate that its opponents are keeping from *No Orchids* by

the advertisement they give it. Whether the outcry is exaggerated or not may be debated, but I am inclined to doubt the harm that the film will do. Brutality and violence are certainly there in abundance, eight murders and one suicide besides indiscriminate killing. But if "sadistic" implies an enjoyment in brutality, then I think the adjective is wrongly applied here and the absence of that quality makes the film less dangerous. (In a way, the film of the concentration camp at Belsen, or a fine picture like the Italian *Open City* with its terrifying portrayal of the Gestapo's delight in cruelty might rouse more dangerous feelings in the audience.) Then too, as well as being brutal, it is certainly vulgar but if it is the vulgar episodes that are to be censored, then the music halls and concert parties all over the country had better take care. There is a third way in which it seems to me that indignation has been exaggerated and defeated its purpose. Many of the criticisms imply that the film is full of horrifying sex incidents, but one may guess that the audience having been led to expect such enormity will come away disappointed. Rape in the novel has become romantic love in the film; the "gangster chief" love is the "real thing" and Miss Blandish never ceases to be refined—in the American slang of this British film, she remains throughout a "classy dame".

It will be interesting to see how long a run this tenth-rate film has. Though misguided clamour has probably lengthened its life, the taste of the public will probably vindicate itself by proving that a film like *No Orchids for Miss Blandish* cannot rival the popularity of *The Best Years of Our Lives*.

P.E.W.

**Corridor of Mirrors.** (*Featuring Eric Portman and Edana Romney.*)

This film is an outstanding example of pure celluloid in which the characters are entirely artificial and never come to life for a moment. It is suggested that the hero is pathological in that he prefers to live in the past rather than the present, but he is merely used as a peg on which to hang the story, and there is no attempt at any elaboration of his personality from the psycho-pathological point of view. The housekeeper is obviously mentally

subnormal and her behaviour is predominantly dictated by her jealousy. This character could have been made interesting, but she is treated merely as a lay figure.

What the film lacks in quality is made up for in the quantity of horrific situations, and it is unlikely that the film would have very much effect on any hardened film goer as it has very little emotional depth and relies entirely on the bizarre and its over elaborate scenic design for its effect.

D.M.O.

*The film industry is one of the largest and most important in the world. It is the only art which the twentieth century has evolved, and it is the fault of the well meaning as well as of the commercial magnate, that what might have become, and may still become, an enormous socializing influence in the lives of the community, should have been allowed to degenerate into a racket.*

J. MACALISTER BREW. "In the Service of Youth."

## Correspondence

(We are glad to publish the following communication which has been forwarded to us by a psychiatric patient after seeing this film.—EDITOR.)

### "MINE OWN EXECUTIONER"

"First and foremost I don't think it should have been publicly shown at all. It gave quite a wrong impression to the public who seem, from what I have heard, somewhat bewildered and nauseated by this subject—bewildered because I don't believe the producers know anything about it. It is a very delicate and obtruse matter to deal with and I feel if it was really necessary for such a film to be shown at all, it should have been prepared by a team of expert doctors, though the trimmings and love scenes could perhaps have been left to the producers! I went to the film with a reasonably normal person and she came away completely condemning and horrified by it. From my point of view, I was glad I saw it, for it proved to me that I was able to face such a film; previously I would have left the cinema almost immediately, but I was determined to stay to see what effect it would have on me.

"My own analysis of the film in its detail is a bit difficult, but I will do my best. First, it presented the very worst aspect of the subject to the public so that youths and young girls behind us laughed and giggled at parts that required the deepest sympathy, thereby missing one of the most important points of the whole film and showing that they failed to appreciate in any way the appalling suffering involved. No sympathy for the patient was aroused nor was one good quality in him brought out. He might have been a criminal for all the public cared!

"Nothing was shown of the part played by the doctor in leading the patient back to normality which would have given hope to parents, sweethearts and friends of mental patients in the audience. Instead one came away with the idea that all mental patients were dangerous and very much to be avoided and no suggestion was given that there were many types and degrees of mental

illness. To a patient the film would convey the idea that he was a hunted social outcast and that no one had any pity, sympathy, understanding or tolerance towards him.

"If most films end happily why not this one, especially as it is on such an important subject? I felt it was bad psychology to show the patient committing suicide. What a wonderful chance to show instead, the respect and confidence of the patient in the doctor, and from then onwards, to bring the picture to a happy end with an ultimate cure.

"Again in the scene where he murdered his wife—why not show how the power of love could dominate his mind, and bring that aspect to the surface? The ladder scene too, gave a great opportunity of showing the power of good over evil, in that the patient must have realized here was his own prop which could help. The instinct of self-preservation would surely have prevented suicide so that he would have surrendered until he could have been helped to stand on his own feet. The scene showing the banalities and trivialities of the psychologist with his girl friend was also bad because of its flippancy. We know doctors require relaxation, but was it necessary to show this? After all, the public build up unconsciously a certain ideal of the medical profession and their standard ought not to be lowered. If humour is required, surely it should be shown through a patient?

"Well, these are only random thoughts, and perhaps I am all wrong; but as I was invited to write, I have done so, although with some fear and trepidation for after all, I am not an expert. I only wish I were, for nothing would give me greater joy than to help my fellow sufferers. May I have the chance to do so?"

X.

## "CERTIFIED"

DEAR SIR.—The review of my book, *Certified*, given in your March issue, seems to demand a statement from its author : if otherwise, the author has wasted six years and £250 in a fruitless endeavour to improve our Mental Health Services and the lot of the mentally ill.

Although this book has been brilliantly reviewed throughout the world, and despite the fact that your reviewer is the only one to accord it an "adverse" review, I must at once agree with him that it certainly does not offer anything in the way of constructive ideas. Therefore, I shall be glad if you will publish this letter, so that your readers may become aware of my purpose.

Today, there is a spate of books written by ex-patients : *The Snake Pit*, *The Kingdom of the Lost*, *Certified*, and (now due from Allen & Unwin) *Inside the Asylum*, by John Vincent. These authors have lived in our mental hospitals and thus gained first-hand experience of the conditions prevailing. They have witnessed the defects in our Mental Health Services ; and consequently, none of them finds any reason to praise the system. On the contrary, they are shocked, horrified and angered that things so wrong should be possible in our mental hospitals as they are constituted today.

Now, although I do not doubt the sincerity of your reviewer (for it is evident that we have the same aim that of promoting by any means the improvement of the mental health of the community) I do feel it necessary to say that there are no inaccuracies in my book, that I have deliberately minimized matters, that it is a terrible fact that there was no treatment for mental disorders in

"my" asylum, nor was there any treatment for physical illness—other than a first aid room.

With regard to your reviewer's justifiable suggestion that part of my book may have been inspired by my own mental disability, I would assure him that I was a perfectly sane man, and that because we were at war when I wrote the book, I was unable to tell the reader how it was that a sane man came to be in an asylum. This is now made clear in my book, *That Which is Caesar's*, which appears in a few weeks' time.

Is it not passing strange that a writer of world-wide reputation (Vera Brittain) should have written the Introduction to John Vincent's book, *Inside the Asylum*? And is it not also strange that many of our largest bookshops are staging an exhibition of my next two books—*Synthetic Mania* and *That Which is Caesar's*? Whole windows are being used, wherein fifty copies of each of these books, together with a poster bearing my photograph and the following advertisement will be seen : "A most courageous and dynamic book."—Vera Brittain.

With all respect to your reviewer, who may himself be a medical man well versed in psychological medicine, may I suggest that so resistant is the human mind to things not yet experienced that one can hardly hope for complete understanding without further explanation.

Yours truly,  
H. G. WOODLEY.

Doune House,  
Edzell, Angus.

## RECENT PUBLICATIONS

**PROBLEMS OF CHILD DELINQUENCY.** By Maud A. Merrill, Professor of Psychiatry, Stanford University, U.S.A. Harrap & Co. 15s.

**PSYCHOTHERAPY WITH CHILDREN.** By Fredk. H. Allen. Kegan, Paul. 10s. 6d.

**PSYCHOTHERAPY IN CHILD GUIDANCE.** By Gordon Hamilton. London. Geoffrey Cumberlege. 22s. 6d.

**THE DOCTOR AND THE DIFFICULT CHILD.** Revised Edition. By William Moodie, M.D., F.R.C.P., D.P.M. Geoffrey Cumberlege. 11s. 6d.

**THE UNKNOWN WORLD OF THE CHILD.** By Dr. Andre Arthur, trans. by Robin Scott. Paul Elek. 9s. 6d.

**THE LIKES OF US.** By G. V. Holmes (a "Barnardo child"). Frederick Muller, Ltd. 7s. 6d.

**LAWLESS YOUTH. A Challenge to the New Europe.** Prepared by International Committee of the Howard League. Allen & Unwin. 10s. 6d.

**EDUCATION AND HEALTH.** By R. Gamlin, M.A., M.R.C.S., L.R.C.P., D.P.H. Nisbet. 12s. 6d.

**PARENTS' QUESTIONS.** By the Staff of the Child Study Association of America. Victor Gollancz. 10s. 6d.

**PSYCHOTHERAPY : ITS USES AND LIMITATIONS.** By D. R. Allison, M.D., M.R.C.P., and R. G. Gordon, M.D., D.Sc., F.R.C.P. Geoffrey Cumberlege. 8s. 6d.

**THE PSYCHO-ANALYTICAL STUDY OF THE CHILD.** Vol. II, 1946. Imago Publishing Co. 30s.

**PRACTICAL PSYCHIATRY AND MENTAL HYGIENE.** By Samuel W. Hartwell, M.D. McGraw Hill Book Co. Inc., U.S.A. \$3.75.

**MODERN PSYCHIATRY IN PRACTICE.** 2nd Edition. By W. Lindesay Neustatter, M.D., M.R.C.P., B.Sc. J. & A. Churchill. 12s. 6d.

**OXFORD ESSAYS ON PSYCHOLOGY.** By William Brown, D.M.(Oxon), D.Sc.(Lond.), F.R.C.P. Heinemann Medical Books. 10s. 6d.

**NORMAL AND ABNORMAL PSYCHOLOGY.** By J. Ernest Nicole, O.B.E., D.P.M. Allen & Unwin. 8s. 6d.

**THE DOCTOR AND THE DIFFICULT ADULT.** By William Moodie, M.D. Cassell & Co. 15s.

**HYPNOTISM TO-DAY.** By L. M. Lepron, B.A., and J. Bordeaux, B.A., M.A. Foreword by M. H. Erickson, M.D. William Heinemann Medical Books. 25s.

**METABOLIC BRAIN DISEASES AND THEIR TREATMENT IN MILITARY AND CIVILIAN PRACTICE.** By G. Tayleur Stockings, M.B., B.S., D.P.M. Baillière, Tindall & Cox. 16s.

**OLD AGE : ITS COMPENSATIONS AND REWARDS.** By A. L. Vischer. Foreword by Lord Amulree, M.D., F.R.C.P. Allen & Unwin. 12s. 6d.

**THE SOCIAL MEDICINE OF OLD AGE.** Report of an Inquiry in Wolverhampton. By J. H. Sheldon, M.D., F.R.C.P. Geoffrey Cumberlege. 5s.

**THE PHILOSOPHY OF A SCIENTIST.** By R. G. Gordon, M.D., D.Sc., F.R.C.P.(Ed.). Hutchinson. 16s.

**JUST MURDER.** By Edward Robinson. Preface by Harold J. Laski. Last Word by Charles Berg, M.D., D.P.M. Lincolns-Prager Ltd. London. 12s. 6d.

**VOLUNTARY SOCIAL SERVICES since 1918.** By Henry Mess. Edited by Gertrude Williams. Routledge and Kegan Paul. 21s.

**TOWARDS PUBLIC UNDERSTANDING OF CASEWORK.** By Viola Paradise, Research Associate, Department of Social Work Interpretation. Russell Sage Foundation, New York. \$2.

**INSIDE THE ASYLUM.** By John Vincent. Introduction by Vera Brittain. Allen & Unwin. 6s.

**FEAR.** By M. P. Leahy, M.B., B.Ch., B.A.O.(Dublin). William Heinemann Medical Books Ltd. 10s. 6d.

## NATIONAL ASSOCIATION FOR MENTAL HEALTH

## Regional Representatives

Region 1	..	..	MISS M. B. SWANN, 129 Clayton Street, Newcastle-on-Tyne, 1.
Region 2	..	..	MISS M. HAMILTON, B.A., 12-14 Oxford Offices, 3/5 Oxford Row, Leeds.
Region 3	..	..	MISS E. V. JONES, 47 Park Row, Nottingham.
Region 4	..	..	MISS C. MCCALL, 26a Hills Road, Cambridge.
Region 5	..	..	MISS HAY-SHAW, 39 Queen Anne Street, London, W.1.
Region 6	..	..	MISS E. M. FINDLAY, Kendrick House, Kendrick Road, Reading.
Region 7	..	..	MISS S. A. ABLEY, Rodney Lodge, Clifton Down Road, Bristol, 8.
Region 8	..	..	MRS. HOLLINGS, 24 The Balcony, Castle Arcade, Cardiff.
Region 9	..	..	MRS. SHAPIRO, M.A., 8 Wellington Road, Birmingham, 15.
Region 10	..	..	MISS PRAGER, 89 Fountain Street, Manchester, 2.
Region 12	..	..	MISS R. S. ADDIS, 31 Upper Grosvenor Road, Tunbridge Wells.

## VOLUNTARY MENTAL WELFARE ASSOCIATIONS OR COMMITTEES

Bournemouth—Miss Buckland, Commercial Road, Parkstone, Dorset. Bucks—H. V. Adams, Esq., County Hall, Aylesbury. Cambridge—Miss F. S. Rogers, 2 Jesus Lane, Cambridge. Cumberland and Westmorland—Miss Moclair, 27 Spencer Street, Carlisle. Darlington—Miss Ruth Robinson, Education Office, Northgate, Darlington. Derby—Miss M. Adams, Council House (Room 35), Derby. Devon—Miss MacMichael, 8 Dix's Field, Exeter. Dorset—Miss Stevenson, Clerk's Dept., Shire Hall, Dorchester. \*Essex—Miss S. C. Turner, 6 King Edward Avenue, Chelmsford. Hampshire—Miss Scott, The Castle, Winchester. Hastings—Miss Rogers, 44 Wellington Square, Hastings. Ipswich—Miss Burdett, 16 Charles Street, Ipswich. Kent—Miss S. G. Nugent, 70 King Street, Maidstone. \*Lancashire (Central)—Miss Dash, 41 Alma Street, Blackburn. \*Lancashire (North)—Miss Celia Cook, 1 Queen Street, Lancaster. \*Lancashire (South-East)—Mrs. Beth McCann, Welfare House, 9 Anson Road, Manchester, 14. Lancashire (West)—Miss F. Andrew, 38 Princes Road, Liverpool, 8. Leeds—J. S. Hoyle, Esq., 25 Blenheim Terrace, Leeds, 2. Leicestershire—Miss E. N. Colman, 6 St. Martin's, Leicester. Lincolnshire (Parts of Lindsey)—Miss E. M. Brown, Eastergate, Massey Road, Lincoln. North Eastern—Miss G. M. Crosse, 22 Ellison Place, Newcastle-on-Tyne, 1. Nottingham—Mr. G. E. Westmoreland, 136 Mansfield Road, Nottingham. Oxford—Miss Buck, Ebor House, Blue Boar Street, Oxford. Oxfordshire—Miss D. Alcock, 1 Becket Street, Oxford. Plymouth—Miss B. Lee, Trematon Villa, Pentillie Road, Mutley, Plymouth. \*Portsmouth—The Chief Clerk, Mental Treatment Department, Anglesea Road, Portsmouth. Sheffield—Miss Stigess, School Clinic, Orchard Street, Sheffield. Somerset—C. E. Newman, Esq., County Hall, Taunton. Southampton—Mrs. Treadgold, 5 Cranbury Terrace, Southampton. Staffordshire—Miss F. Tosh, Craberry Chambers, Craberry Street, Stafford. Suffolk—Miss Robertson, 13 Crown Street, Ipswich. Sunderland—Miss Histon, 7 Murton Street, Sunderland. Surrey—Miss Kerry, 39 South Street, Epsom. Sussex—E.—Mrs. Ayshford Ayre, Castle Gate House, Castle Gate, Lewes. Walsall—Miss Grant, Room 21, Council House, Walsall. Wiltshire—Miss Cowie, County Offices, Trowbridge. Wolverhampton—Miss E. Bottomley, Town Hall, Wolverhampton. Worcester—Miss J. Tree, 8 Stephenson Terrace, Worcester. Worthing—Mrs. Nevell, 113 Marine Parade, Worthing. \*Yorkshire (North Riding)—Miss M. Davies, 5 New Street, York. \*Yorkshire (York City and East Riding)—Miss M. Gaunt, 1 Museum Street, York.

For addresses of Child Guidance Clinics, apply to Child Guidance Department, National Association for Mental Health.

\* Mental Welfare Department of Local Authority.

## LOCAL MENTAL HEALTH SOCIETIES

Birmingham and Midland Branch, N.A.M.H.—Hon. Sec., T. Jefferson Cottrell, Esq., 40 Carpenter Road, Birmingham, 15. Bath and Bristol Mental Health Society—Chairman, Dr. Elizabeth Casson, St. Margaret's, Castle Road, Walton St. Mary, Oldham Council for Mental Health—Hon. Sec., Mrs. Jackson, Heybank, Frains Road, Delph, Oldham, Lancs. [Clevedon] Devon Committee for Education in Mental Health—Hon. Sec., Miss F. M. Dickinson, Ridgeway Close, Ottery St. Mary. Windsor Mental Health Association—Hon. Sec., J. H. Wallis, Esq., 10 Peacock Street, Windsor. Bournemouth Association for Mental Health—Hon. Sec., Miss Haskett Smith, Spurfield, Dane Court Road, Parkstone, Dorset.

